State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

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1.3 Table of Contents

1.4 Overview of the State

Unlike many states, North Dakota (ND) is experiencing a declining population. Many youth continue to migrate out of the state and other residents are moving from the more rural and frontier counties to more urban areas for better employment opportunities. The state now has less than 8,000 births per year. These trends impact our frontier areas and have resulted in difficulty in maintaining services, including health care, in some areas of the state. Despite the decrease in population and births, the state continues to fund eleven public universities across the state in addition to two private universities.

The ND Legislature did not meet in 2000 so recent changes in legislation have not occurred. However, in the interim, the Health Department has been asked to develop a plan for use of tobacco settlement funds. During the 1999 Legislative Session, it was determined that tobacco funds be divided as follows: 45% water projects; 45% common school fund; and, 10% for public health. Although these funds will not be allocated for spending until the 2001 Legislative Session, the State Health Officer has presented a plan for their use to the Interim Legislative Committee. The issue has generated a high level of public interest so further debate is anticipated before consensus is reached as to how tobacco settlement funds will actually be spent in the state.

Governor Edward T. Schafer has announced he will not run for reelection this fall so the state will have new Executive leadership in 2001. The current governor has started the budget process for the upcoming biennium. State agencies are to maintain their current budget level; a positive change from the usual cut in state general funds required in recent biennial budgets.

Agriculture continues to play a major role in the state's finances. Reports of a depressed farm economy are reported on the news continually. Regionally, some areas are experiencing difficulties related to flooding. Grand Forks, a city located in the Red River Valley, experienced major flooding in 1997. The Devils Lake area continues to battle an ongoing flood situation as well. Severe flash flooding occurred in Fargo this June.

The state's population is largely Caucasian. Native Americans are the largest minority group representing nearly 5% of the population but close to 10% of all births in the state. There are pockets of refugees in the state from the former Soviet Union and Somalia. This population presents its own unique concerns for health care compounded by language and cultural differences. There are also a limited number of seasonal migrant workers in the eastern part of ND. Migrant health services in the state are administered by the state of Minnesota.

North Dakota now has local public health departments in all but two of its 53 counties, a total of 26 local public health agencies. Legislation passed in 1999 mandated that all public lands have coverage by a health department by January 1, 2001. For the most part, local public health departments provide primary preventive, population-based health care. All local staff have been offered, and most have participated in, core public health function training using the state of Washington model. The Title V MCH Division collaborates with local health agencies to carry out state MCH objectives at the grass roots level.

Most medical care in the state is provided by private health organizations. The majority of medical specialists are located in the eight major cities in the state. Being a large state geographically, extensive travel for health care is required. Several rural hospitals are seeking status as critcal access hospitals to remain open and viable. At a minimum, preventive primary health care services and emergency care need to be provided in frontier areas.

The Native American population receives services in a variety of ways. Indian Health Service (IHS) is a provider of health care but is reportedly under-funded. Native Americans who leave the reservations can receive basic care from IHS but cannot be referred for contracted services outside the IHS service area.

Native American Reservations and Service Area continue to be funded for the federal Healthy Start program. Two of the reservations have formed a non-profit organization for fiscal purposes. Staff from the MCH Division are on the advisory board of Healthy Start, Inc.

The Medicaid Program administers the ND Healthy Steps Program (SCHIP). Regional Healthy Steps Workshops sponsored by the Dakota Association of Community Health Centers, Inc. in partnership with the ND Medical Association and the DHS were held fall 1999. Many public health and county social service representatives attended and staff now provide outreach support for the program. The enrollment in Healthy Steps continues to grow. As of 6/30/2000, 1,860 children were enrolled; 170 or 9% of which were Native American children. Enrollment in the program is tracked by county level so outreach efforts can be targeted to areas where it is most needed. Use of TANF funds to conduct outreach on one ND reservation is being explored.

In cooperation with the Medicaid Program, the state applied for and received a Robert Wood Johnson grant to increase outreach activities for ND Healthy Steps. The Children's Services Coordinating Committee is the lead agency, however the Community Health Care Association (PCA) directs the project. Outreach is focused on two population groups, Native Indian families on two ND reservations and farm/ranch families statewide. The fiscal agent for the farm/ranch family pilot is the Mental Health Association of ND while the fiscal agent for Native Indian families is Healthy Start, Inc. A fourteen-member Covering Kids advisory board has been established and includes representation of the State Health Officer and the Executive Director of DHS. Medicaid and the Community Health Care Association will conduct evaluation of the grant.

With financial support from businesses, community and church groups and individuals, the ND Caring Foundation provides the Caring Program for Children, a specially designed health and dental benefit program for eligible children who are not covered by or eligible for Medicaid or other health insurance. Blue Cross/Blue Shield of ND in cooperation with the Dental Service Corporation of ND contributes all administrative costs for the program. The Caring Program for Children is an additional resource for families that do not have a source of health care coverage.

The Medicaid managed care pilot project in Grand Forks County continues. Medicaid may expand the program to surrounding counties in the region. Clients in the area have their choice of the managed care plan or a primary care provider. The percent of Medicaid recipients that chose the managed care plan dropped this past year from around 60% to 40%. HMO activity outside Medicaid has not changed from previous years.

There is concern in the state that declining enrollment in Medicaid may be linked to changes in social welfare. Temporary Assistance to Needy Families (TANF), a program that replaced Aid to Families with Dependent Children (AFDC), may have resulted in families assuming they were not eligible for medical assistance when they actually were still eligible for the program. This concern may be addressed as enrollment in ND Healthy Steps continues.

In February 2000, 2,742 ND families received TANF, 36% less than in February 1997. By racial breakdown, 40.1% were white, 57.5% American Indian, 2.2% Black and 0.2% Asian.

North Dakota received the Health Resources and Services Administration (HRSA) and Health Care Financing Administration (HCFA) Initiative entitled "CompCare." The state has

requested assistance in two areas. Once children are enrolled in a health care plan, help is being requested to ensure these children receive primary preventive health care. Secondly, assistance is being sought in sorting out the health care options available to the Native American population living both on and off the reservation. Acceptance of ***Bright Futures*** as best practice for pediatric health care is also under consideration.

1.5 The State Title V Agency

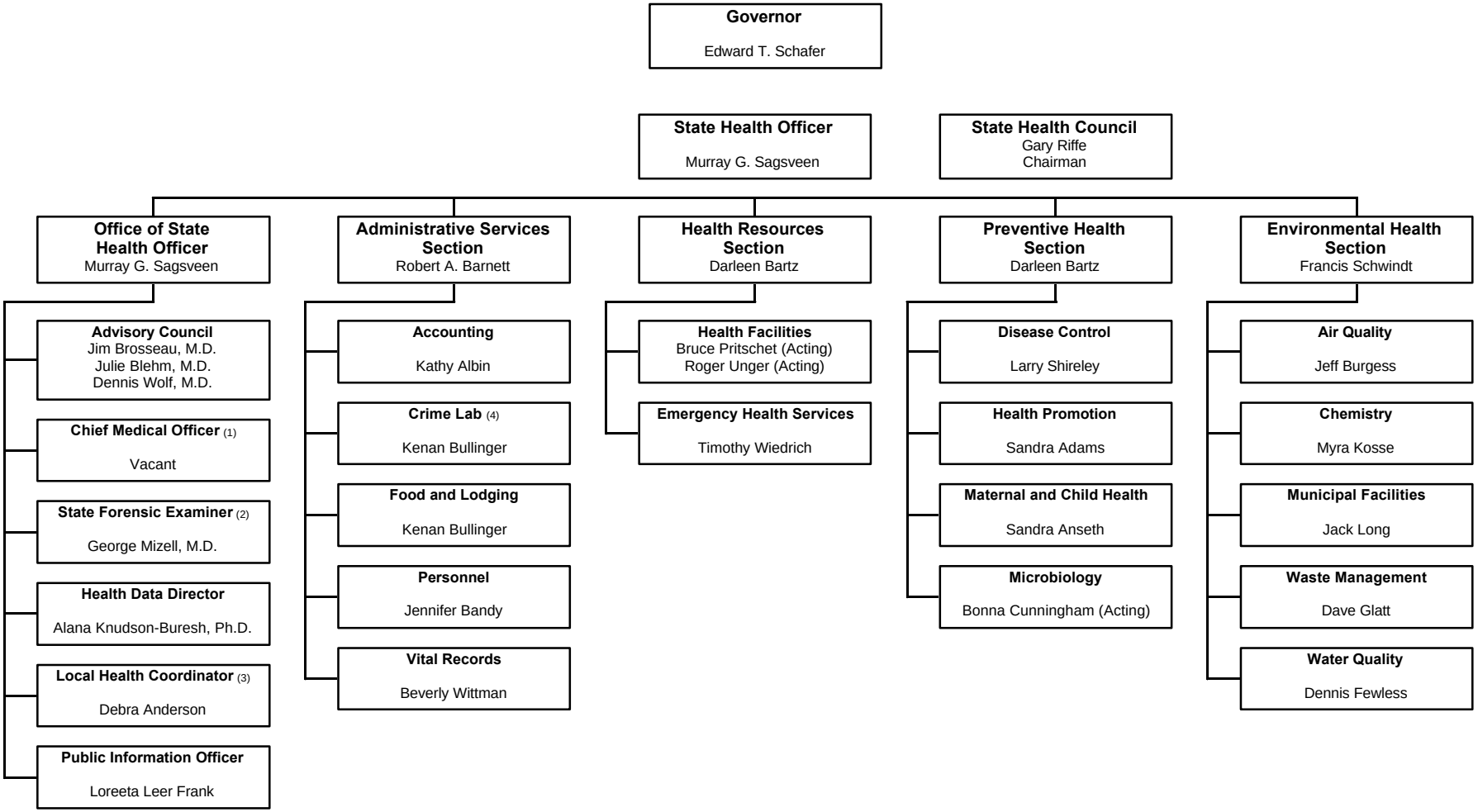
1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

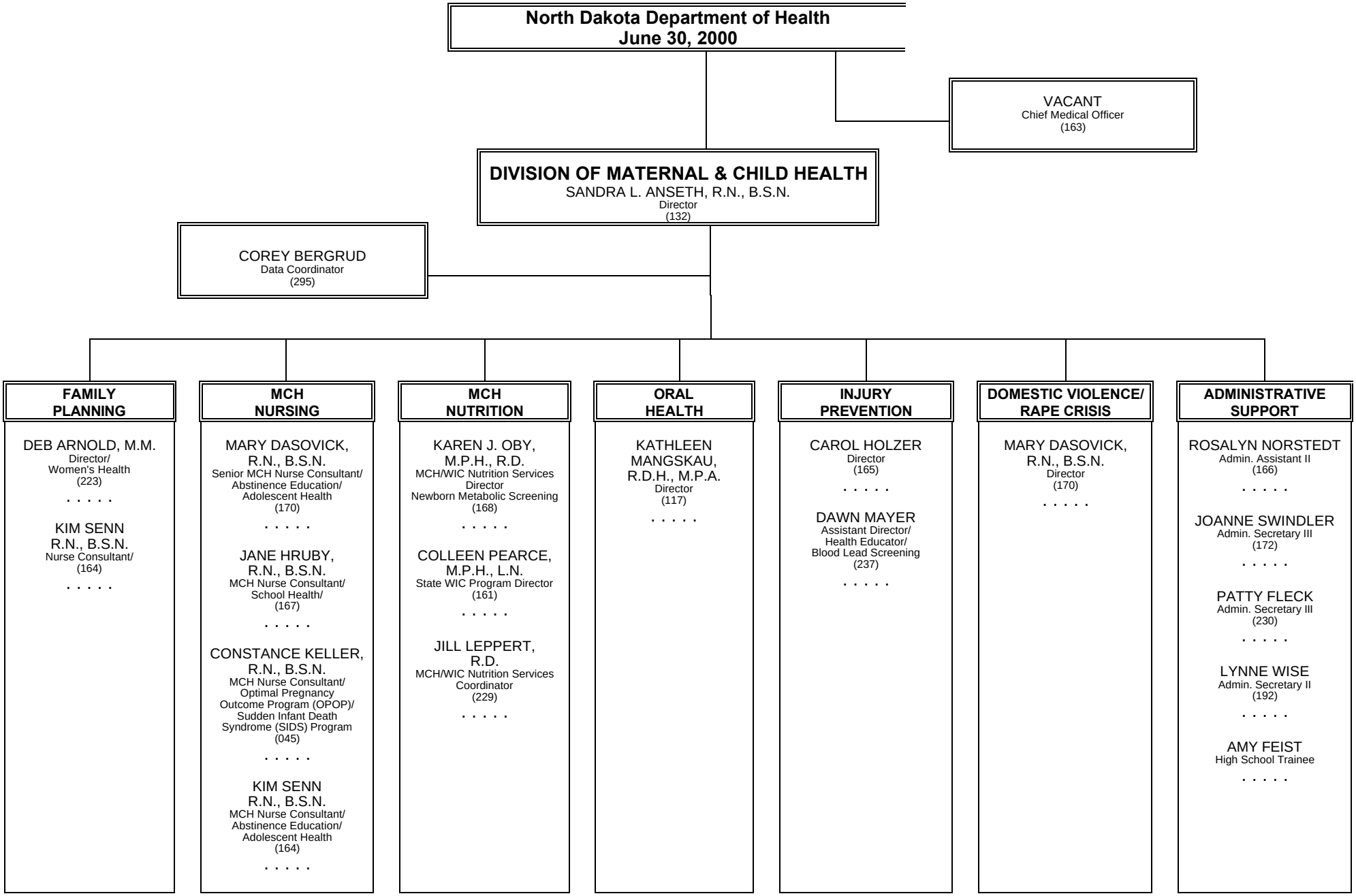
The State Health Officer of the DoH is responsible for the administration of programs carried out with allotments made to the state by Title V. The Governor of the state appoints the Health Officer. The DHS administers the portion of funds allotted for children with special health care needs. The Governor also appoints the Executive Director of this department. Organizational charts of the two departments follow.

NORTH DAKOTA DEPARTMENT OF HEALTH

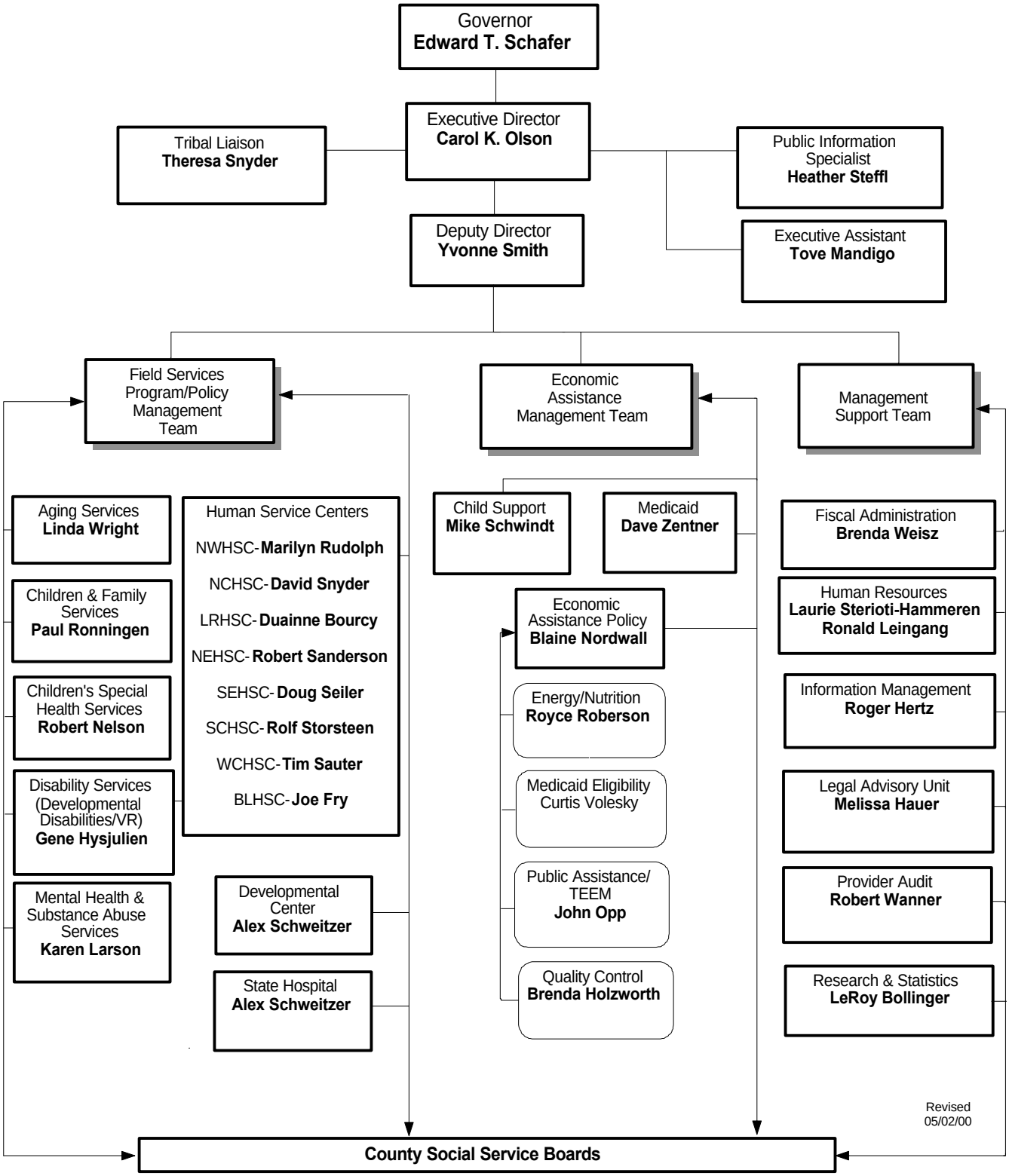
JUNE 30, 2000



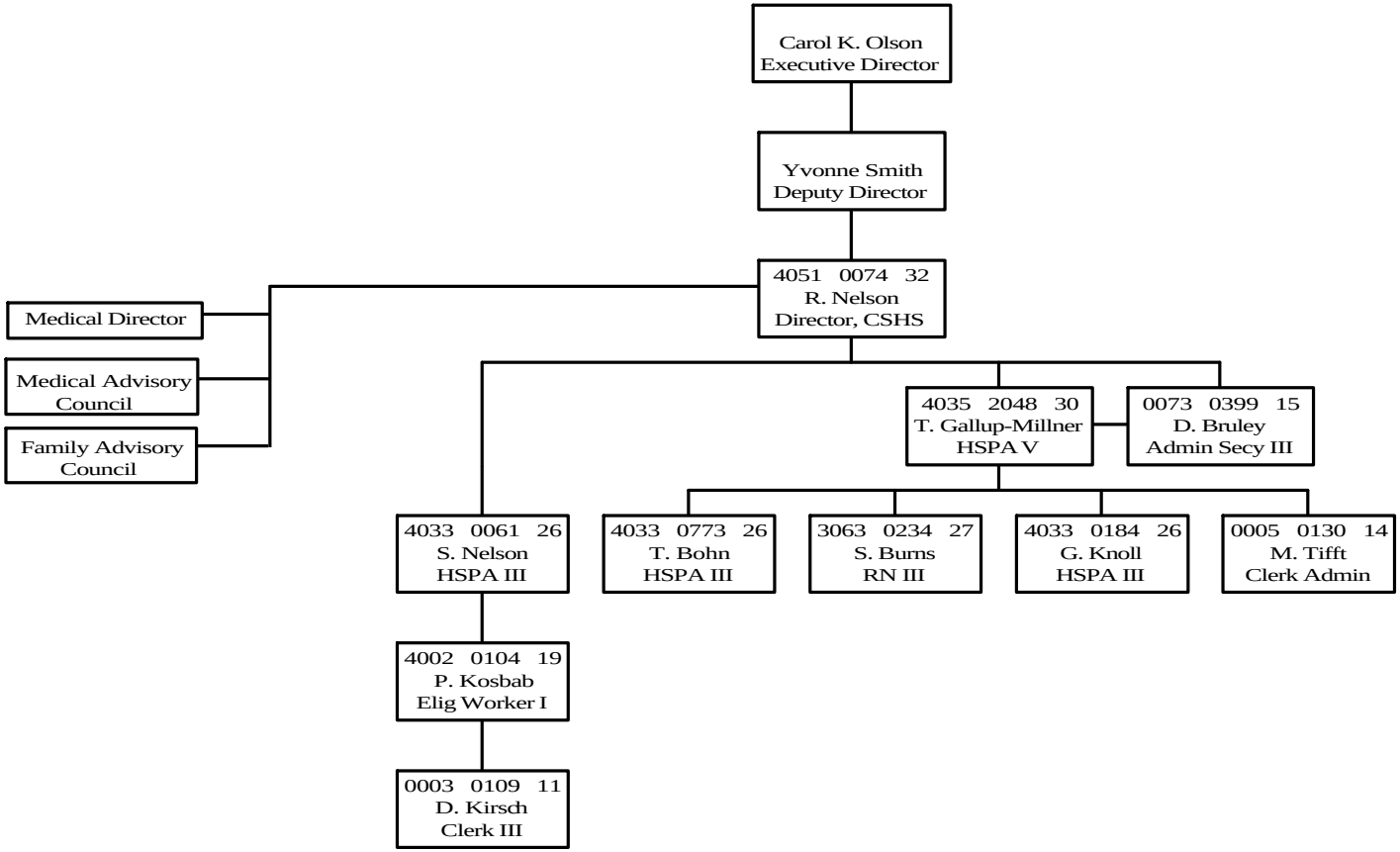
Telephone No: 701.328.2493
Fax No: 701.328.1412
Toll-Free No. (within North Dakota): 1.800.472.2286



North Dakota
Department of Human Services



North Dakota Department of Human Services
Children's Special Health Services Division



Revised
05/29/99

Local health departments are autonomous and not part of the DoH. Their relationship is cooperative and contractual. In the DHS, county social service boards work cooperatively with the state agency in administering programs and services.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, ND Century Code (NDCC). The MCH Division of the DoH has statutory authority to accept and administer funds for the following programs: MCH/Title V, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The MCH Division administers the STOP Program in turn. The NDCC mandates newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1).

The DHS through the CSHS Division administers programs for children with special health care needs. Administrative duties of state and county agencies and confidential birth reports for newborns with visible congenital deformities are addressed in NDCC Chapter 50-10.

1.5.1.2 Program Capacity

Various programs within the two departments and divisions contribute to the health of the maternal and child health population within the state. The Optimal Pregnancy Outcome Program (OPOP) provides nursing, nutrition and social services to at-risk pregnant women which augments the care women receive from their primary health care provider. Services are available at ten local sites within the state's eight regions and target low-income women who are at increased risk for adverse pregnancy outcomes, such as adolescents, abused women, and those who are developmentally delayed or emotionally impaired.

Local public health departments provide grass roots primary preventive services to women and infants such as prenatal classes, immunizations and other related health programs. Part of the funding used to provide these services are Title V MCH grant funds to local agencies. Two Native American Reservations receive funds to augment Healthy Start Programs in their area.

The MCH Domestic Violence/Rape Crisis Program grants federal and state funds to domestic violence/rape crisis, prosecution, law enforcement, and other community agencies to address the issues of domestic violence and sexual assault through collaborative and coordinated efforts. The program provides technical assistance to the contracted agencies and maintains statewide domestic violence and sexual assault data through a grant to the ND Council on Abused Women's Services.

The Birth Review Program is a collaborative program, the purpose of which is to identify at-risk newborns through information from the birth record, provide parents with information on risks and related health care concerns, and link families to early intervention and other support programs. It is part of a larger effort known as ChildFIND, whose purpose is to identify all children with disabilities. The Division also collaborates with the Children's Trust Fund, the ND Nurses Association and others to publish and distribute ***Parenting the First Year*** to all new parents in the state.

The MCH Nurse Consultant is involved in other women and infant programs and issues such the Fetal Alcohol Syndrome Task Force, the March of Dimes, NCAST and Infant Massage training and Newborn Home Visiting.

The state's Sudden Infant Death Syndrome (SIDS) Management Program provides support, education and follow-up to parents/caregivers, family and childcare providers suffering a sudden infant death. Since most autopsies for SIDS are now conducted by the State Forensic

Medical Examiner's Office, the MCH Division pays for few autopsies. The program coordinator collaborates closely with the ND SIDS Chapter affiliate.

The Newborn Metabolic Screening Program currently screens newborns for phenylketonuria (PKU), hypothyroidism, galactosemia and congenital adrenal hyperplasia (CAH) through the University of Iowa's Hygienic Laboratory. The Chief Medical Officer and MCH staff does follow-up of positive and borderline cases. Iowa provides free monitoring of PKU levels for children so afflicted. Special metabolic formulas have been provided to children with PKU and MSUD and some low protein foods are provided to Medicaid and uninsured children.

The MCH Oral Health Program develops guidance for prevention and care for mothers and children, provides expertise in state efforts to review and revise rules and regulations and control oral diseases. Program staff collaborates with public and private groups to assure policy/program development with an emphasis on improving access to oral health care. The program supports the maintenance of school-based fluoride and sealant programs and provides support for oral health outreach services at public health clinics. Eight Title V funded regional dental health consultants provide training, technical assistance and consultation to local agencies to build capacity for oral health needs assessment and health promotion and prevention efforts. These efforts focus on maintaining school-based fluoride programs; promoting use of dental sealants; and providing dental health education for mothers and children with an emphasis on the prevention of early childhood caries, orofacial injuries, and tobacco use.

The MCH Injury Prevention Program's mission is to reduce the number and severity of injuries to North Dakotans, with special emphasis on injuries to children. A full-time administrator, a half-time assistant and a quarter-time secretary staff the program. Program staff provide training, technical assistance, and materials to local entities to develop community-based intervention projects. The program coordinates with the Department of Transportation, US Consumer Product Safety Commission, and the ND Nurses Association. Program staff are active participants in the Safe Kids Coalition, Emergency Medical Services for Children project, Child Fatality Review panel, Shaken Baby Syndrome Task Force, and the ND Adolescent Suicide Prevention Task Force.

The MCH School Nurse Program's mission is to support the educational process by contributing positively and significantly to the health, health attitudes and health behaviors of today's children and consequently, tomorrow's adults. The program is staffed by a 45% RN director and promotes and supports school nursing as part of the comprehensive school health program. The program assists in the coordination of statewide school nurses meetings for the purpose of program updates and sharing resources. The program provides technical assistance for school health services including scoliosis, vision and hearing, and safety issues for students, teachers and support staff.

The ND Abstinence-Only Education Grant Project grants federal funds to Regional and Tribal Children's Services Coordinating Committees (R/TCSCCs) to carry out abstinence-only education activities at the local level. The project coordinator provides technical assistance to local agencies and maintains statewide data for annual reporting purposes.

The MCH Women's Health Coordinator's responsibility is to disseminate information regarding women's health and to facilitate the collaboration of programs, which enhance women's health. The goal is to develop a broader perspective of what contributes to the health and welfare of women as they live longer and provide this information to researchers, policy makers and the health care providers.

The MCH Family Planning Program provides supplemental funding to the Title X Program. The intent of the overall program is to provide individuals with the information and means to exercise personal choice in determining the number and spacing of their children. Program staff assure that individuals have access to a broad range of acceptable and effective family planning methods, including natural family planning and services to adolescents as evidenced through service plans and protocols developed by all contracting agencies. Technical assistance, training and materials are provided to contracting agencies to accomplish this goal.

The MCH Nutrition Program funds nutritionists to promote nutrition through emphasis on the ten essential public health functions adapted to nutrition activities. Although some individual counseling is done by local MCH nutritionists, emphasis is placed on population-based interventions such as the 5-Plus-5 Program, school-based interventions such as teacher in-services and breast feeding promotion. Working with school-aged children and adolescents to promote healthy eating and exercising behaviors is a top priority. MCH nutrition staff coordinate meetings with other state nutrition program staff and local nutritionists for the purposes of program updates and sharing of ideas and materials.

The Nutrition Program for Women, Infants and Children or WIC Program was created to promote and maintain the health and well being of nutritionally at-risk women, infants and young children. This is accomplished through the provision of supplemental foods, nutrition education and counseling and referrals to health and social support programs. Pregnant, breast feeding and recently delivered non-breast feeding women, their infants and children up to age five are eligible if they meet income guidelines and have a nutritional need. The ND WIC Program contracts with 28 local public and private not-for-profit health agencies to serve 14,000 ND residents each month.

The Health Passport Project (HPP) uses a secure smart card (a credit card with a computer chip) to store medical and other information that families need to obtain services across programs. Bismarck WIC and Head Start began issuing cards in June. North Dakota HPP partners programs include Bismarck WIC, Head Start, Public health for the MCH funded prenatal programs, immunizations, Medicaid and the EPSDT Program, Family Doctors (a private clinic) and Blue Cross/Blue shield of ND (the largest insurance agency in the state and which manages the statewide immunization registry). As a "passport" this tool helps families gain access to health and support services, while reducing duplication of records for providers.

The MCH Nurse Consultant for children and adolescents participates and collaborates in a number of health related issues. Part of the responsibility is acting as coordinator for adolescent related health concerns. Consultation is provided on a number of topics such as scoliosis, pediculosis, health and safety issues related to childcare, growth and development and discipline. The nurse consultant is involved in various policy issues, one of them being the development and updating of the MCH Manual for local agency use.

Local agencies including public health agencies conduct primary preventive health services for the child and adolescent populations. Injury prevention, nutrition and oral health issues are some of the health issues addressed. Funding from Title V MCH assist them in these efforts. One school nurse program is funded at the Standing Rock Indian Reservation.

Payment for authorized services to qualified providers serving eligible children with special health care needs is provided through the Specialty Care Program in order to increase access to pediatric specialty care. Through this program, CSHS supports both diagnostic and treatment services. CSHS promotes early diagnosis of over 100 medical conditions. Families must

complete an application for diagnostic services at their county social service office but financial eligibility is not required. The CSHS Medical Director determines medical eligibility and other state-level staff provides technical assistance to county social service staff in the application process and authorizes payments for care. CSHS also pays for a variety of services needed to treat a child's eligible medical condition. Families apply for treatment services at their county social service office. Both medical and financial eligibility is required. The CSHS Medical Director determines medical eligibility at the central office. Other state-level staff develops policy and procedures, provide technical assistance in the application process and training of county social service staff, and authorize payments for care. Income eligibility has recently been raised to 185% of the federal poverty level and assets are no longer considered. CSHS maintains a list of approved health care providers who have agreed to participate in the program.

Comprehensive pediatric evaluations and coordinated care recommendations for children with special health care needs are provided through the Multidisciplinary Clinic Program in order to help families effectively manage their child's chronic health condition in the most efficient manner. Clinics are available for children whose chronic health conditions are best managed through a team approach. CSHS either directly administers or sponsors the following eight types of clinics: Cleft Lip and Palate Clinics, Scoliosis/Orthopedic Clinics, Cardiac Care for Children Program, Metabolic Disorders Clinics, Cerebral Palsy Clinics, Developmental Assessment Clinics, Myelodysplasia Clinics, and Diabetes Clinics. Over 80 clinics are held each year across the state, half of which are coordinated by CSHS. The other half is funded through contracts with hospitals, health systems and universities. Families are not billed for clinic services; however, third-party payers may be used, if available. State-level nursing staff provides clinic coordination services for programs directly administered by CSHS. State-level staff also carries out technical assistance, training and quality assurance activities. A network of public and private health care providers across the state participates in the program and local county social workers affiliated with CSHS staff many of the clinics. The Multidisciplinary Clinic Program provides a secondary benefit in the state as an avenue for pre-service training, particularly for nursing and speech/language students.

Community-based case management services for children with special health care needs and their families are provided through the Care Coordination Program in order to assure access to necessary, comprehensive services. Public health nurses currently provide care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in five eastern counties of the state. Care coordination responsibilities of county social service staff in all 53 ND counties were recently expanded to better serve children eligible for treatment services through CSHS. State-level staff provides technical assistance, training and quality assurance activities to support this program and work to align service coordination activities throughout the DHS.

Through CSHS Administration, leadership and support is provided to state and local partners so they can implement health service system improvements. Primary partners include families, county social service staff, health care providers and related program administrators. In addition to direct services for children with special health care needs and their families, CSHS provides the following public health services to promote maternal and child health in ND:

- Public information services – CSHS functions as a family resource center and conducts a variety of outreach and public education activities.

- Training, consultation and technical assistance – CSHS provides technical assistance, training and consultation to county social service and public health nursing staff.
- Planning and policy development – CSHS works with others to address identified needs of CSHCN and their families (e.g.) Medicaid, state legislature etc.
- Needs assessment, performance monitoring and quality assurance – The State Systems Development Grant supports these critical Title V efforts.
- Coordination and collaboration – CSHS staff participate on a number of committees, advisory boards, workgroups and task forces (e.g.) Family and Medical Advisory Councils.

1.5.1.3 Other Capacity

The Preventive Health Section Chief is Darleen Bartz. She received a bachelor's degree in nursing from Jamestown College (1977), a masters in nursing (1987) and a masters in management (1989) from the University of Mary and a Post Graduate Family Nurse Practitioner Program Certificate from Clarkson College, Omaha Nebraska (1997). She currently is licensed in the state of ND as a Family Nurse practitioner and an Environmental Health practitioner. Darleen has held a variety of management positions with the department over the past ten years and has participated in several health care policy workgroups and committees. Prior to joining the department, Darleen had a wide variety of work experiences as both a manager and staff nurse in both the public health and acute care settings.

Sandra Anseth, the MCH Division Director, has a bachelor's degree in nursing with eleven years with the DoH, the last four and a half as MCH Division Director. Previous experience in the DoH included Family Planning Program Nurse Consultant, MCH Nurse Consultant and assistant director for MCH. Sandra had over 13 years of experience as a staff public health nurse in local public health agencies prior to joining the health department in addition to various experiences in acute and long term care health facilities. The director is a member of the ND Nurses Association, ND Public Health Association, the ND Mental Health Association, the Association of Retarded Citizens (ARC), and the National Association for the Education of Young Children (NAEYC). She was appointed by the Governor to the ND Council on Developmental Disabilities and serves on a variety of boards, committees and task forces including the State Child Protection Team and the Child Fatality Review Panel.

MCH STAFF FUNDED BY TITLE V

Staff	FTEs	Qualifications
Director	1.0	BS in Nursing
Nurses	2.15	BS in Nursing
Nutritionist	0.9	MPH, Licensed Registered Dietitian
Nutritionist	0.1	Licensed Registered Dietitian
Dental Hygienist	1.0	MPA, Registered Dental Hygienist
Dental Hygienist (Temporary)	0.6	Registered Dental Hygienist
Program Administrator	1.0	BS in Business Administration
Health Educator	1.0	BA in Health
Support Staff	1.0	Administrative Assistant II
Support Staff	1.7	Administrative Secretary II
Data Processing Coordinator	1.0	BS in Computer Science
Total MCH-funded staff	11.45	

MCH STAFF NOT FUNDED BY TITLE V

Family Planning Program		WIC Program	
Director	1.0	Director	1.0
Contracted Nurse Practitioner	0.2	Nutritionist	1.0
Support Staff	0.3	Support Staff	1.0
Domestic Violence and STOP Program		Abstinence Education Program	
RN Director	1.0	RN	0.3

In addition, the MCH Division has access to various staff located within the Office of the State Health Officer. These include: Chief Medical Officer for the DoH works closely with many MCH Programs such as the Newborn Metabolic Screening Program (the current position of Chief Medical Officer is vacant). Debra Anderson is the DoH's liaison with local public health units and other key public and private partners. Debra administers the State Block Grant, which provides general funds to local public health departments and advises the State Health Officer about issues related to local public health. Debra joined the DoH in August 1996 and became the Local Health Coordinator in March 1998. She is a graduate of the University of ND and has worked in advertising and public relations for Blue Cross and Blue Shield of Oklahoma. Dr. Alana Knudson-Buresh is the Health Data Director and supports the DoH by providing consultation on health-related data and research projects. Alana Knudson-Buresh received a B.A. from Luther College, Decorah, Iowa, a dual Ed.M. degree from Oregon State University, Corvallis, Oregon and a Ph.D. from Oregon State University. Her doctorate is in Public Health with emphases in health policy and statistics. Dr. Knudson-Buresh served as a researcher for the ND Health Task Force, a project funded by the Robert Wood Johnson Foundation State Initiatives Program. As a researcher for the DoH, she has designed studies, analyzed data and presented study findings in local, state and national forums. She is currently the Director of the Office of Health Data and oversees research studies and data projects for the department. In addition, she serves as the Assistant Coordinator for the Turkmenistan-ND Partnership Project, an international health

development project funded by the United States Agency for International Development (USAID). Dr. Knudson-Buresh also holds a Clinical Assistant Professor position at the University of ND School of Medicine and Health Sciences and is a part-time faculty member at the University of Mary. She teaches graduate courses in bio-statistics and conducts post-graduate seminars on data and health economics. Larry Shireley, the Disease Control Director/State Epidemiologist, has primary responsibilities of the state epidemiology including coordinating studies, investigations and surveillance activities, conducting data analysis and providing technical expertise and consultation with public and private health professionals. Michael J. Mullen is a Senior Advisor for Health Policy with the DoH, which he joined after service with the ND Health Task Force. In this capacity, he reviews DoH programs and policies and makes recommendations about program development to the State Health Officer and the State Health Council. In addition, the senior advisor prepares reports about the cost and utilization of health care services and drafts legislation and testimony related to health care issues. He is also a Clinical Assistant Professor of Family Medicine at the University of ND School of Medicine, and Adjunct Professor of Health Care Law and Health Care Policy at the University of Mary. Mr. Mullen received a B.S. in Chemical Engineering from the University of Notre Dame and a J.D. from the Georgetown University Law Center. From 1961 to 1965, he served as a Lieutenant in the United States Marine Corps.

The Director of the CSHS Division has a Master of Science degree in social work and a long history of service at the state and regional levels within state government. Professional experiences include two years as director of a regional field office, three years as administrator of Program Operations in the State Capitol, and 20 years experience in his current position. Mr. Nelson is a member of the Program and Policy Management Team, which reports directly to the executive Director of the DHS.

The Deputy Director of the CSHS Division is a licensed, registered nurse with a Master of Public Administration degree. Professional experiences include four years as a hospital staff nurse and 16 years of experience within state government. Prior to 1991, Ms. Gallup-Millner was an assistant clinical supervisor within CSHS. In this job, she provided consultative nursing services and was responsible for CSHS multidisciplinary clinics. Ms. Gallup-Millner is a member of several professional organizations and serves on many committees, advisory boards and task forces.

CSHS STAFF FUNDED BY TITLE V

Staff	FTEs	Qualifications
Division Director	1.0	MSW
Deputy Director	1.0	MPA, Registered Nurse
Administrators	3.0	MSA, BSN, and HSPA III
Nurse	1.0	BSN
Eligibility Worker	1.0	Eligibility Worker I
Support Staff	3.0	Administrative Secretary III, Administrative Clerk, and Clerk III
Total CSHS-funded staff	10.0	

CSHS contracts for the services of a part-time Medical Director, Dr. Robert M Wentz. In addition to his medical degree, Dr Wentz received a graduate degree in Public Health from the University of California in 1980. He has had many noteworthy professional experiences including several years in the State Health Department as MCH Director, Section Chief and State Health Officer. Currently, Dr. Wentz is a practicing pediatrician in Bismarck, ND. He became CSHS Medical Director in September of 1999.

Parents of special needs children have not been hired within CSHS. However, the Division does support a nine-member Family Advisory Council. Members are reimbursed mileage, meals and lodging and are paid a $75.00 consultation fee for each quarterly meeting they attend.

CSHS also has access to various management support personnel within the DHS. Of particular importance are staff within the Research & Statistics Unit who provide critical support in data analysis for CSHS surveys. In is anticipated that Research & Statistics staff will play an important role in future program evaluation efforts.

1.5.2 State Agency Coordination

The Title V Maternal and Child Health Program has in place a Memorandum of Agreement effective until June 30, 2001 between programs in the ND Health and Human Services Departments. DoH programs include the Maternal and Child Health (MCH) Division, WIC Program, Family Planning Program, Optimal Pregnancy Outcome Program, Immunization Program, Diabetes Control Project, and the Health Passport Project. Programs in DHS include Children's Special Health Services (CSHS) Division, Medicaid, ND Health Tracks (EPSDT) and Head Start.

The MCH Division is also signatory to a Memorandum of Agreement with the ND Primary Care Office (PCO). Others included in that agreement are the Dakota Association of Community Health Centers, Inc. (DACHC) representing the Primary Care Office (PCO) in ND, Health Resources and Services Field Office (FO), State Systems Development Initiative (SSDI), and the State Office of Rural Health (SORH). This agreement is in effect until March 31, 2001.

Under the Health Passport Project information may be provided by participants designated representatives of ND Health Tracks, Medicaid, the Immunization Program and providers of Title V (MCH) services. This information may be used for the purposes of establishing the eligibility of applicants for the programs/services mentioned, for conducting outreach for such programs, and for updating health/demographic records of the local provider. Local service providers will promote and refer persons in need to programs that provide health and social services to women and children and their families. This authorization shall be considered valid for the duration of the Health Passport demonstration, but not to exceed two years from the date signed.

The Primary Care Office now has a presence within the DoH. This change has facilitated communication between the two offices. One example is their close working relationship with the MCH Oral Health Program to address dental shortage. The Primary Care Office (PCO) continues to monitor manpower shortage areas.

The State Regional/Tribal Children's Services Coordinating Committee serves as another conduit to the grass roots level. These committees were established by legislation to assess community needs, develop plans to address these needs and then help fund activities directed towards meeting community needs. Representatives from health, human services, education, vocational education, the judicial system and others are part of the Children Services Coordinating

Committees. The MCH Division works closely with these committees on a variety of health-related issues.

The MCH Division works closely with the Childcare Division within the DHS on the MCHB Grant for addressing health and safety issues in childcare settings. The grant provides funding for part-time nurses to act as consultants for the ChildCare Resource and Referral agencies and childcare community.

The Division is involved in the implementation of a grant to the Mental Health Association of ND (MHAND) intended to improve child health care in the state. The grant was awarded to the MHAND for the Fargo region. The original intent was to conduct outreach for the ND Healthy Steps (SCHIP) Program. The purpose of the grant as received addresses support for families of children with emotional disorders, education of providers and creation of educational material.

Staff from Title V are members of the Fetal Alcohol Syndrome Task Force. This is a multi-agency, multi-discipline and consumer task force addressing FAS issues. North Dakota is part of a four-state consortium that is applying for a federal grant to deal with this issue. The Task Force may serve in an advisory capacity, if requested by the grantee.

The MCH Nurse Consultant position was changed to include 5% time for collaboration with the State Genetics Program. Although the state did not receive grant funds to develop a statewide genetics plan, the planning process may continue and the consultant will be the contact staff to work with the genetics staff at the University of ND.

The MCH Division has a close working relationship with local health departments as they carry out the majority of primary prevention and population-based services that contribute to better health for the maternal and child population. The survey of local agencies conducted last year indicated they were overall satisfied with the MCH Division goals, objectives and staff. There has been an increased effort to include nurses and other staff from the Native American Reservations in meetings and educational offerings held by the state. For instance, the directors of nurses from the reservation health programs are invited to attend the local health department DON meetings and their staff nurses are invited to regional nurses meeting.

An interagency agreement to facilitate development of an early intervention system for at-risk and special needs children, birth through five years of age, and their families was signed in 1994 and remains in effect until terminated. The parties to this agreement are the DHS, Department of Public Instruction, DoH, the United States Department of Health and Human Services as the agency for Children and Families, and the Children's Services Coordinating Committee.

A Memorandum of Agreement between Shriners Hospitals for Children and the DHS (CSHS) went into effect October 1998. The intent of this agreement is to increase access to services and resources through collaboration, referrals and information sharing. An addendum to the agreement broadens the collaboration to include Vocational Rehabilitation Services.

The MCH and CSHS Divisions have close ties to staff in the Denver Branch Office. The liaison for the state provides useful consultation along with other expert staff in Denver. The Region VIII Division Director conference calls are helpful, as are the cluster calls involving nurses and social workers.

The DHS is a large umbrella agency that includes many of the service agencies relevant to the MCH population. The Program and Policy Management Team within DHS, of which CSHS is a part, includes mental health, social services/child welfare, alcohol and substance abuse,

vocational rehabilitation, and developmental disabilities programs. The Title V program works closely with other DoH and DHS sections, divisions and programs. Individual MCH and CSHS Programs have their own network of partners and collaborative efforts, both formal and informal. Much of this is portrayed on the accompanying table.

State agency coordination occurs through participation on a wide array of interagency efforts on behalf of children with special health care needs and their families. CSHS staff participates on the following:

- Interagency Coordinating Council
- March of Dimes Subcommittee
- Family-to-Family Support Network Advisory Board
- Emergency Medical Services for Children Advisory Board
- Universal Newborn Hearing Screening Advisory Board
- Chronic Disease Workgroup
- ND PASS Project
- Fetal Alcohol Syndrome Task Force
- Genetic Advisory Committee
- Birth Review Committee

For additional details regarding collaborative efforts, see Table 1 on the following page.

Table 1 - North Dakota Title V Program Collaboration with Other State and Local Agencies

Agencies	* Collaboration	** Degree of Collaboration
Public Sector: Health		
Medical Examiner's Office	1-6	2
Medicaid / EPSDT / Targeted Case Management for Pregnant Women	1-6	3
Mental Health	1-6	2
Substance Abuse/Including Tobacco (FAS Task Force)	1-6	3
WIC	1-6	3
Head Start / Early Head Start	1-6	3
Ryan White & Title IV AIDS Program; STDs	1-6	2
Family Planning	1-6	3
Indian / Tribal Health Services / Healthy Start (Grants)	1-6	3
Dental Health	1-6	3
Other Health: (Immunizations)	1-6	3
Other Health: (Health Promotion & Education)	1-6	3
Other Health: (Local Public Health)	1-6	3
Public Sector: Education		
Early Intervention (Part C) / NDECTS	1, 2, 6	3
Special Education (Part B / School-Age Children)	4, 5, 6	3
Elementary and Secondary School (School Nurses)	4, 5, 6	2
Department of Public Instruction (Child Nutrition Programs)	4-6	3
Social Services		
Vocational Rehabilitation	6	1
Native American Liaison	6	2
Temporary Assistance to Needy Families (TANF)	4-6	1
Family Support Services / MCH Directory / Family Network / Family Support Groups (ICC; SIDS; Sibshops; Oasis)	1-6	3
Protective Services (Abuse & Neglect; Domestic Violence)	1-6	2
Foster Care and Adoption Assistance Program	6	1
Women's Way Breast and Cervical Cancer Program	2	2

Agencies	* Collaboration	** Degree of Collaboration
Social Services (Cont'd.)		
Supplemental Security Income Program / DDS	6	2
Child Care / Resources & Referral	1-6	2
Other Social Services (ETs; CSHS County Workers)	6	3
Other Public Sector		
Genetics	1-6	2
Information Technology Division (ITD)	1-6	3
Governor's Office (CSCC Data; Domestic Violence)	1-6	2
State Legislature (Budget Interim Reports)	1-6	2
Criminal Justice Program (Domestic Violence / CSCC / FAS)	1, 2, 6	2
Developmental Disabilities Program (Case Management)	1-6	2
Other Public Sector: (Center for Rural Health; PCO / PCA)	1-6	3
Other Public Sector: (Higher Ed / NDSU Extension; SCRIPT)	1-6	2
Other Public Sector: (Department of Transportation)	1-5	2
Other Public Sector: (EMSC)	3-6	3
Other Public Sector: (Indian Affairs Commission)	1-6	1
Other Public Sector: (Homeless Programs)	1,2,5	2
Private Sector		
Service Providers (Shriners; Clinic Coordinators; MAC Members)	6	3
Employers	--	--
Insurers (ICC; Payment; CHIP; Data / Insurance Department)	1-6	3
Advocacy Groups (March of Dimes; Family Voices; NAFNS; Pathfinders; PASS; ND Council on Abused Women's Services)	1-6	3
Other Private Sector: Professional Organizations (AAP; NDNA; NDDA; NDNC; NDDHA)	1-6	2
Other Private Sector: ND Center for Persons with Disabilities	6	3
Other Private Sector: ND SIDS Chapter	1-6	3

CODE KEY:

*Collaboration:
1 = Pregnant Women
2 = Non-pregnant Women of Reproductive Age
3 = Infant
4 = Children
5 = Adolescents
6 = Children With Special Health Care Needs

**Degree of Collaboration
1 = Minimal Interaction
2 = Moderate Interaction
3 = Weekly/Monthly Interaction/MOAs

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

The differential between amount budgeted and amount expended on Form #3 is reflected in the amount of unobligated funds in the CSHS Division in the DHS and the match budgeted for these unobligated funds. CSHS utilizes primarily general fund match rather than local match. The state legislature has not approved enough general funds to allow for an increased rate of spending. This has been and will continue to be an ongoing problem since a "hold even" general fund budget has been requested for the next state biennium as well. The only alternative is to explore use of local provider match. This differential also carries over into the subsequent Forms #4 and #5.

The following table indicates amount budgeted for 1999, amount expended and the difference between the two figures:

Population	Budgeted	Expended	Difference
Maternal	$ 412,991.00	$ 391,894.00	- $ 21,097.00
Infant	$ 826,061.00	$ 783,789.00	- $ 42,272.00
Child	$ 983,731.00	$1,175,683.00	+$ 191,952.00
CSHCN	$2,120,923.00	$1,195,241.00	- $ 925,682.00

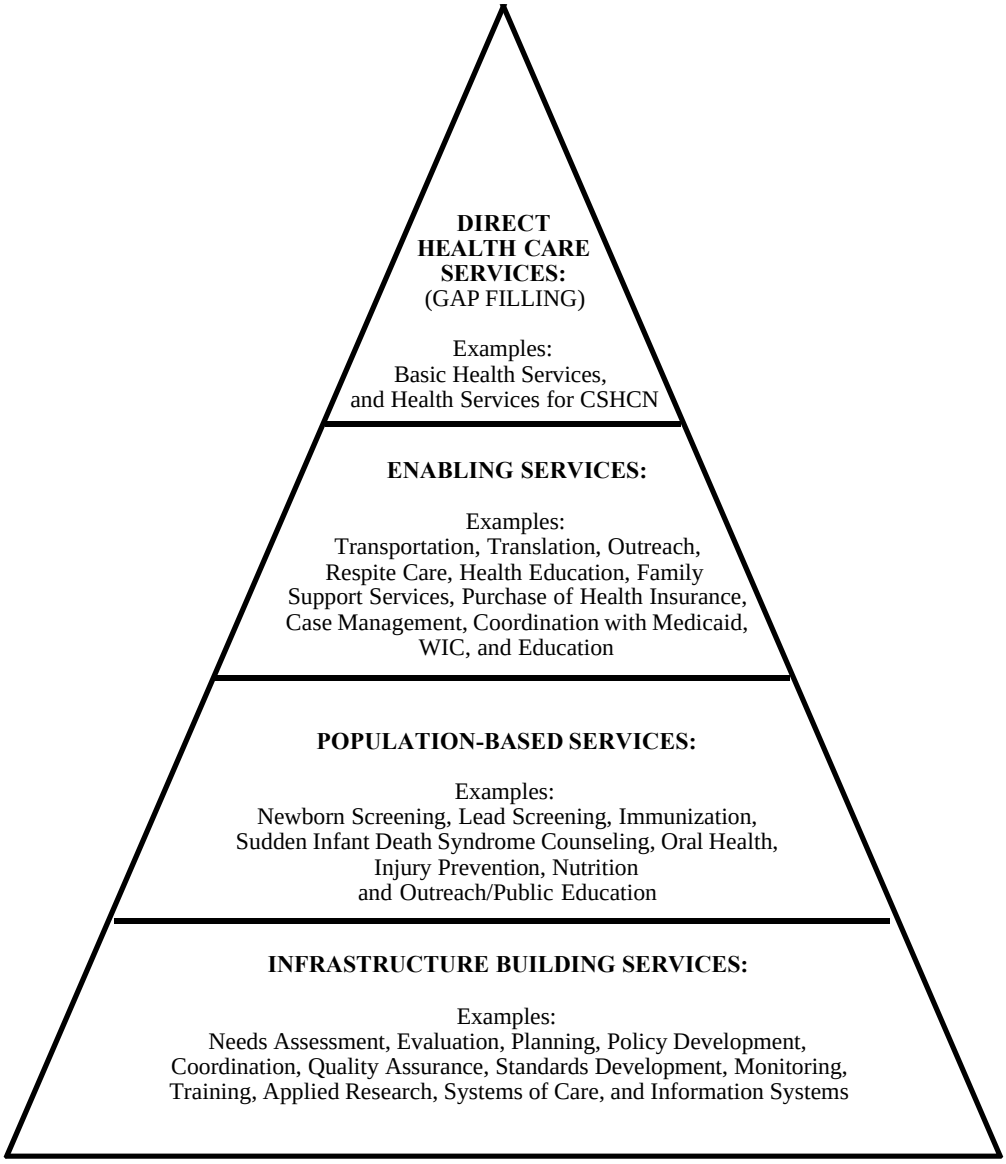
Other is $120,000.00 for the Family Planning Program and $44,508.00 for indirect costs. Total budget for the MCH Division is $2,515,874.00. CSHS expended $1,220,988.00 during FY '99, which includes $25,747.00 for CSHS administration.

Justification for Form #5 MCH Division: $1,164,040.00 expended for Infrastructure Building Services, primarily state level expenses, indirect costs and some local health expenditures; $1,231,834.00 for Population Based Services reflecting local agency expenditures; and $120,000.00 for Direct Health Care Services for the Family Planning Program expenditures. Total $2,515,874.00.

Justification for Form #5 CSHS Division: $438,579.00 expended for direct health care services including claims and contract payments; $219,124.00 expended for enabling services including family support and care coordination services; $79,805.00 expended for population-based services including outreach and public education; and, $483,480.00 expended for infrastructure building services including CSHS medical director, state-level staff, and information system. This totals $1,220,988.00.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

Forms #6, #7, and #8 give information on number of individuals served. The information for Form #6 is obtained from the Iowa Hygienic Laboratory because they conduct the newborn screening tests for ND. Since out-of-state and repeat tests are included, the number is higher than actual ND births. Because of a lack of a client-based system in the Maternal and Child Health Division, some of the numbers are estimated on Form #7. Information for Form #8 is obtained from Vital Records Division of the DoH and the DHS.

2.3 State Summary Profile

Summary information is found on Form #10 in Section V. of this application.

2.4 Progress on Annual Performance Measures

Progress on each of the annual national and state performance measures may be found on the tables in this section of the grant application.

2.4 Progress on Annual Performance Measures

NORTH DAKOTA ANNUAL REPORT – 1999
(Activities from 10/01/98 – 09/30/99)

Type: C **Category: DHC** **X Federal State**	**Performance Measure #1:** The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. **Healthy People 2000 Objective:** 7.14				
Actual FY '98 PM **9**	**Projected PM:**	**FY '99** **7**	**FY '00** **7**	**FY '01** **7**	**Actual FY '99 PM** **9**

Narrative: The target for this performance measure was exceeded. The number of ND children birth to age 21 on SSI decreased by 10% from FY '96 to FY '99. For children under age 16, the decrease was slightly higher at 12%. An initial decline in SSI-eligible children was expected during this time in response to the 1996 Welfare Reform mandate for stricter disability criteria. Over the last five years, about 80% of SSI recipients in ND have been eligible for Medicaid and 15% have been Native American, ND's largest minority group. In FY '99, 88 SSI beneficiaries less than 16 years old received rehabilitative services from CSHS. An adjustment in future target projections may be needed for this measure based on available trend data.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
During FY '99, CSHS will promote the SSI Program for children with special health care needs and their families.	CSHS staff will conduct outreach mailings to CSHS families on SSI.	Accomplished. In September 1999, CSHS conducted an outreach mailing to 1600 families who had children receiving SSI. Information was provided about a variety of programs and services, including CSHS, Medicaid, the Family to Family Network, and Health Tracks. A health information card was also included so parents could request additional information to meet their family's specific needs.
	CSHS staff will collaborate with Vocational Rehabilitation staff and the Choices Project regarding transition planning for children over 16.	CSHS, Vocational Rehabilitation and Special Education staff attended a Choices Conference April 1999. In follow-up to that meeting, a targeted mailing was conducted during the summer of 1999 to 318 families whose children were served through CSHS that were age 16 or older. The mailing included information about

		SSI and plans for achieving self-support, Medicaid eligibility, Vocational Rehabilitation, Education/Special Education and Health Care. In addition, collaborative planning to establish a transition camp for CSHCNs was initiated. Ongoing outreach and collaborative activities were also conducted. Over the course of the year, 376 SSI brochures/information packets were distributed by CSHS. Interagency work group efforts with DDS, SSA and Medicaid were encouraged through an annual meeting convened by CSHS staff.

Type: C **Category: DHC** **X Federal State**	**Performance Measure #2:** The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. **Healthy People 2000 Objective:** 17.2; 21.4; 17.14				
Actual FY '98 PM **8**	**Projected PM:**	**FY '99** **8**	**FY '00** **8**	**FY '01** **8**	**Actual FY '99 PM** **8**

Narrative: CSHS provided or paid for eight of the nine services addressed within the performance measure, meeting the target established for FY '99. Changes in performance targets are not expected in the near future. The number of children receiving specialty services provided or paid for by CSHS over the last five years has remained relatively constant with an average of 1,742 children served annually between FY '95 and '99. In contrast, provision of public information services has increased within CSHS during the same time. Families touched by these activities are currently not counted as having received specialty services provided or paid for by CSHS.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
During FY '99, increase the number of children attending multidisciplinary clinics and programs.	Evaluate reasons why families do not attend a clinic or program when invited.	Partially Accomplished. All workplan activities were completed during the year but the number of children attending multidisciplinary clinics supported by CSHS did not increase. Statistical reports reflect a 2% decrease in attendance at multidisciplinary clinics between FY '98 and 1999. Since 1995, however, clinic attendance increased by 5%.

		To begin to evaluate attendance issues, staff compiled a baseline "no show" rate for 20 cleft lip/palate clinics supported by CSHS that were held at five different sites during FY '99. The "no show" rate was 24%.
	Promote referrals from new sources.	A data field to identify referral sources was included in a new client server computer application developed by CSHS during FY '99. Reports, once generated, will provide baseline data about referrals for children served through CSHS effective FY '00. CSHS assessed the number of new referrals to cleft clinics. New referrals increased from 27 in FY '98 to 32 in '99. In addition, nearly 600 more annual clinic schedules were disseminated to public and private providers in FY '99 as compared to FY '98. The clinic schedule contains referral information for CSHS multidisciplinary clinic services.
	Develop a listing of multidisciplinary clinics in the state.	A statewide resource containing *all* multidisciplinary clinics available in the state for CSHCNs and their families was developed and disseminated in FY '99.
During FY '99, continue to pay for diagnostic and treatment services for eligible children.	Finalize revisions to CSHS Policy and Procedural Manual.	Accomplished. During FY '99, 277 children received treatment services and 192 children received diagnostic services that were paid for by CSHS. Only minor changes were made in financial and medical eligibility criteria for diagnostic and treatment services during the year, however, coverage for outpatient medications was enhanced. A final draft of the CSHS policy and procedure manual was completed September 1999. It

		was distributed to county social service workers at an annual training event October 1999.
During FY '99, CSHS will provide outreach, information and referral services for families and professionals to improve access to services and to promote quality care.	CSHS workgroup will develop a social marketing plan to enhance library loan resources and activities, to provide discrete outreach efforts to at-risk populations, and to provide general social marketing activities for the Division.	Accomplished. CSHS provided a variety of public information services during the year. Activities are reflected in an annual report that was disseminated to MCH, Medicaid, and DHS public information staff, as well as CSHS Family Advisory Council members and a Family-to-Family Network representative. Staff within the CSHS state office essentially operate a family health information center which includes the following services: • Toll-free "Info-Line" • Targeted outreach, information & referral efforts • Resource library • Educational/consultative services • Other media/social marketing events & activities Each year, a plan is developed by CSHS that describes public information services/activities the division expects to achieve. During FY '99, 97% of the plan activities were accomplished.
By September 30, 1999, CSHS will develop a plan to meet orientation, training and technical assistance needs of CSHS county workers.	Develop orientation outline and curriculum.	Accomplished. Through work of the Consumer Involvement committee, a daylong CSHS county social worker training opportunity was organized for October 4, 1999. The event was coordinated with an in-service for Health Tracks (EPSDT) Program staff to minimize travel required by county social service personnel. Three CSHS training objectives were identified: 1) to improve understanding of CSHS as a public health program, 2) to enhance the ability of county social service staff to administer the CSHS program at the community level, and 3) to

		improve county social service care coordination skills.
	Organize "Day in the Field" experiences with county staff.	Five “day in the field” experiences occurred during FY ‘99 with the following partners: • Infant Development Program • Regional CSCC • School nurses • Standing Rock Reservation • Child Evaluation & Treatment Program
During FY ‘99, CSHS will continue development of an integrated, computerized information system within CSHS.	CSHS will enhance its computer programs used to obtain care coordination and CSHS client data.	Accomplished. CSHS developed a new client server application during FY ‘99 that integrated a variety of critical business functions conducted within the division.
	CSHS will have the program from SDX and TECS rewritten to obtain more accurate SSI data.	Minor modifications in the computer program were requested and completed. The new SSI report generated off the SDX/TECS systems provides data needed for outreach mailings in addition to providing the Medicaid status of SSI eligible children.
	CSHS will complete development of its Web page.	CSHS has several pages on the DHS web site. The CSHS Family Advisory Council reviewed content about CSHS that was included on the site and made suggestions to enhance usefulness of the family-friendly information.

Type: C **Category: ES** **X Federal State**	**Performance Measure #3:** The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home." **Healthy People 2000 Objective:** 21.3

Actual FY ‘98 PM	**Projected PM:**	**FY ’99**	**FY ’00**	**FY ‘01**	**Actual FY ‘99 PM**
91		**91.5**	**92**	**92.5**	**92**

Narrative: Data for this performance measure has been collected through periodic administration of CSHS family surveys. Baseline data was obtained in 1993 and subsequent data became available in 1999. In the most recent family survey, medical/health home was defined as a usual source or place of care with a regular provider. 92% of families that responded indicated having a medical/health home compared to 91% in 1993, slightly exceeding the projected performance target. Annual data for this measure continues to be difficult to obtain for the entire population of CSHCNs in the state. Projections for this performance measure will be revised for the FY '01 Application.		
Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
By September 30, 1999, increase the number of CSHCNs in the state who have a medical/health care home with quality health supervision.	Promote Health Tracks. Continue promotion of Bright Futures Health Supervision Guidelines. Provide information on managed care programs.	Accomplished. CSHS state-level staff and local care coordinators routinely provide information about Health Tracks (EPSDT) screening and refer families with Medicaid-eligible children for services. The annual Health Tracks participation report indicates a screening ratio for FY '99 of 0.48, the same as in FY '98. Quarterly meetings with Health Tracks as well as other Medicaid program administrators were scheduled on a quarterly basis during the year. A cooperative agreement between Medicaid and Title V is available. CSHS continues to purchase new Bright Futures resource materials that are made available to others upon request through library loan. With encouragement of the Interagency Coordinating Council, two local Bright Futures projects continued to operate. MeritCare Health System implemented one project and a second was supported by GST Educational Services. CSHS provided 145 brochures on managed care for CSHCNs and their families as part of the division's ongoing public information services.
During FY '99, CSHS will enhance infrastructure building efforts by	CSHS will identify new partners in the system of services and participate in new	Accomplished. CSHS actively participated on several external

actively promoting maternal and child health.	coordination efforts on behalf of CSHCN and their families.	committees, workgroups, and advisory boards, including but not limited to: • Emergency Medical Services for Children • March of Dimes • Interagency Coordinating Council • Fetal Alcohol Syndrome Task Force • Family-to-Family Network Advisory Board • Chronic Disease Workgroup • Parents and Supportive Schools Advisory Board • Genetics Advisory Board

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #4:** Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (combined). **Healthy People 2000 Objective:** 14.15

Actual CY '98 PM	**Projected PM:**	**CY '99**	**CY '00**	**CY '01**	**Actual CY '99 PM**
100		**100**	**100**	**100**	**100**

Narrative: We continue to meet this objective, although we believe there are some infants that are missed in screening each year. The screening lab routinely receives a greater number of samples labeled "initial screen" than there are occurrent births. We had planned to match ND birth certificate with the Newborn Screening data to determine who we may have missed (home births, emergency deliveries, etc.) However, during FY '99, the University Hygienic Laboratory of Iowa, which does the newborn screening tests for ND, was in the process of designing a new computer programs with web-based access for follow-up and reporting of client data. Consequently, they did not have the time to provide us with the information we needed. The new program became operational on 10-01-2000.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Determine the rate at which infants born at home obtain a newborn screening.	Cross check birth certificate information with newborn screening database.	Postponed until FY '00

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 5:** Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, Hepatitis B. **Healthy People 2000 Objective:** Revised Objective 20.11

Actual CY '97 PM	**Projected PM:**	**CY '98**	**CY '99**	**CY '00**	**CY 01**	**Actual CY '98 PM**
83		**82.5**	**83**	**83.5**	**84**	**79.8**

Narrative: The reported rate of immunizations decreased by 3.2 percentage points in 1998. There may be two reasons for this decrease. The methodology for conducting the national survey on immunizations was changed. In addition, because of the relatively small number of families interviewed, the confidence interval is 5-7 points. In 1999, legislation was passed to allow parents to refuse immunizations for reasons other than religious. This exemption change only slightly increased the number of school-age children NOT receiving their immunizations. The MCH Programs will continue to place emphasis on immunizations.		
Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Supplement funding for administration of immunizations.	Provide funding to local agencies to fund immunization administration.	Fourteen local health departments used MCH/Title V funds for immunization administration. In addition, MCH collaborated with Medicaid, Governor's Office and Immunization Program to mail out the Youth Health Record and immunization record to parents of all newborns in the state.
Provide training on administration of immunizations.	Update Immunization Section of the MCH Manual.	The MCH Forms/Manual Committee has been communicating with the Immunization Program in the Disease Control (DC) Division of the DoH about updating their immunization guidelines.
Collaboration between Immunization Program and MCH.	Participation and input from immunization staff at Memorandum of Agreement meetings.	The Immunization Program, DC Division is signatory to the MOA.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #6:** The birth rate (per 1,000) for teenagers aged 15 to 17 years. **Healthy People 2000 Objective:** 5.1

Actual CY '97 PM	**Projected PM:**	**CY '98**	**CY '99**	**CY '00**	**CY '01**	**Actual CY '98 PM**
16.9		**16.9**	**16.8**	**16.7**	**16.6**	**19.2**

Narrative: The projected level for teenage births was not reached, with an increase in teen births of 2.3, from 16.9 in 1997 to 19.2 in 1998. Because of our relatively small numbers, just a few changes in raw data can make a significant change. This 2.3 increase was an additional 30 teen births. This issue will be addressed by continuing to apply for Abstinence-Only Education funds, supporting the Family Planning Program and other adolescent health activities.		
Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
MCH involvement in writing Welfare Reform state plan for reducing out-of-wedlock births.	MCH participation on Welfare Reform Task Force and subgroup on reduction of out-of-wedlock births.	MCH contributes to the Welfare Teem effort to reduce teen pregnancy through the FPP and participation in the Abstinence Education Grant. Two local public health departments use MCH

		funds for teen pregnancy reduction activities.
Participation in abstinence education grant by state.	Write abstinence education grant. Contract with R/T CSCCs/LHDs to support local projects related to abstinence education.	The MCH Division wrote and received the Abstinence Education Grant. Funds were allocated to Regional/Tribal Children Services Coordinating Committees to fund abstinence related activities.
MCH involvement in St. Alexius Task Force to reduce teen and out-of-wedlock birth on the Standing Rock Indian Reservation	MCH participation on task force and attending meetings and giving input for MCH perspective. Provide statistics on births.	Since staff changes at St. Alexius have occurred, activities related to this project have been discontinued. Information from the project has been shared with other groups.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #7:** Percent of third grade children who have received protective sealants on at least one permanent molar tooth. **Healthy People 2000 Objective:** Revised Objective 13.8

Actual FY '97 PM	Projected PM: FY '98	FY ' 99	FY '00	FY '01	Actual FY '98 PM
52	52.5	53.0	53.5	54.0	46

Narrative: Although the current rate of 46% is lower than the 1997 level, the 1998 rate was based on a convenience sample that may not be representative of the population. Collecting sealant prevalence data is too resource intense to do on an annual basis in a small state such as ND. Students were not resurveyed in FY '99. We will do a random sample in FY '00 to provide a comparison to our FY '97 data. We continue our efforts to promote sealants to the public through our education objectives and support for placement of sealants for low-income uninsured children. These efforts should assist in reaching our target for the performance measure.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Develop and implement protocol for standardized data collection of dental sealant data among third graders.	Develop/adapt protocol for data collection based on the National Screening Training Program recommendations. Train oral health/nursing staff in standardized data collection techniques.	The ASTDD Basic Screening Surveys Model was chosen as the survey tool. The parent consent/questionnaire was modified to meet state needs. The eight regional oral health consultants were trained in use of the Basic Survey Screening Model in August 1999 and local nursing staff are being trained as the model is being used in their region.
Distribute information on dental sealants.	Continue to provide information on dental sealants in school health education programs.	Information on dental sealants was provided to 707 third grade students in 56 schools.

	Update listing of sealant education materials and distribute to local health agencies.	The sealant education materials listing was updated in August 1999 and provided to local health agencies.
Support local dental sealant initiatives.	Continue to provide technical assistance and funding support.	The MCH Division continues to provide funding support for the sealant initiative at the Family Health Care Center in Fargo. The initiative provided sealant coverage for 11 low-income children who had no other source of dental care coverage.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #8:** The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. **Healthy People 2000 Objective:**					
Actual Running Average CY '95-'97 PM 4.1	**Projected PM:**	**CY '96-'98 4.1**	**CY '97-'99 4.1**	**CY '98-'00 3.9**	**CY '99-'01 3.9**	**Actual Running Average for CY '96-'98 PM 4.3**

Narrative: The major accomplishment for this objective involved an upgrade of the state's child passenger safety law. The new law requires children under age four to use a car safety seat and children from four through 17 to ride in a car seat or seat belt. The law is a primary enforcement law that covers all seating positions in the vehicle. The penalty is one point against the license of the driver. Observation surveys show that restraint use decreases with the age of the child, 97% of infants in a car seat, 79% of toddlers in a car seat or seat belt, and 60% of children aged 6-10 in a seat belt. Misuse of car seats is a problem with most car seats having at least one error in use, so training for health professionals and law enforcement was an important component of the injury prevention program.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Increase proper use of child restraints and seat belts by children under age 11.	Continue coordinating educational campaigns to encourage proper use of car safety seats and seat belts. Provide training to local agencies on technical aspects of child restraints/seat belts.	A special campaign, "Elephants Never Forget to Buckle Up" was done during February's Child Passenger Safety Week. Two NHTSA four-day Child Passenger Safety Classes were done, with 42 participants. Five individuals were certified as instructors. Three two-day trainings were conducted with 48 participants. Three classes were taught to new law enforcement at the Training Academy with 75 students. Car seat check-ups were conducted at 15 sites with approximately 500 seats inspected.

	Develop a campaign to promote use of booster seats by children over 40 pounds. Conduct car seat mis-use check-ups. Support legislation to close gaps in the state's child passenger safety law.	A campaign, "Give Your Child A Boost" was kicked off through local public health and Safe Community programs. Educational materials and 625 booster seats were distributed. The Injury Prevention Program received a $75,000.00 grant from the National Highway Traffic Safety Administration to increase booster seat use for children 40 to 80 pounds. The funds were subcontracted to Custer District Health Unit serving a four-county area. The Injury Prevention Program sponsored legislation that increased the age for required car seat use to 4 (from 3) and for seat belt through 17 (from 10). A news conference was held, news release sent, and materials distributed statewide to promote the new law.
Increase use of bike helmets by children.	Provide technical assistance, educational materials, bike helmets and incentives to encourage use of bike helmets.	1,600 helmets were provided to 34 sites to conduct neighborhood block parties. The department supported legislation to require helmet use for children under age 14. The legislation passed the Senate, but failed in the House.
Review deaths to children from motor vehicle crashes.	Participate in Child Fatality Review Panel, which reviews deaths to all children under age 18. Coordinate with ND Department of Transportation and ND Highway Patrol to review crash reports to determine restraint status, alcohol involvement, etc.	MCH staff participated in the Child Fatality Review Panel. Crash reports were reviewed for the Child Fatality Review Panel. The program worked closely with DOT and Highway Patrol to review fatality and injury data and develop programs based on need.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 9:** Percentage of mothers whom breastfeed their infants at hospital discharge. **Healthy People 2000 Objective:** 2.11

Actual CY '98 PM	Projected PM:	CY '99	CY '00	CY '01	Actual CY '99 PM
57.7		58	59	61	57.9

Narrative: The objective was met, but we have remained at the same level for two years. In addition to the activities reported below, in August 1999, the ND WIC Program purchased $16,000.00 worth of TV and radio time through the ND Broadcasters Association ($8,000.00 WIC matched by $8,000.00 from the ND Broadcasters Association). A total of 37 radio stations and 7 TV stations representing 22 cities throughout the state ran the breast feeding promotion spots, most of them in prime time. In addition, in August, WIC sent letters to all ND OB/GYN and Family Practice physicians, asking them to promote breast feeding. Many local health agencies coordinated local activities to coincide with the media spots and physician letter.

Annual Performance Objective(s): 10/1/98-9/30/99	Workplan Activities:	Status/Measurement:
Begin the planning process for the 2000 statewide breast feeding conference.	Contact MCH/WIC nutrition staff in First District Health Unit. Provide them with planning information from past conferences.	Accomplished. Conference was held June 12, 2000.
Publish annual report of breast feeding rates by facility.	Request breast feeding report from newborn screening lab. Calculate sole and combined breast feeding rates. Distribute to hospitals.	Rates were calculated and made available upon request, but no formal report was issued. Will issue report in conjunction with June 2000 conference.
Begin development of home visit standards for promotion and support of breast feeding.	Review resources on standards for home visit assessment and support of breast feeding. Have standards reviewed by lactation consultants, WIC staff and home visiting nurses.	Six local health departments use MCH funds to promote breast feeding.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 10:** Percentage of newborns who have been screened for hearing impairment before hospital discharge. **Healthy People 2000 Objective:** 17.6 and 17.16				
Actual FY '98 PM **39**	**Projected PM:**	**FY '99** **40**	**FY '00** **50**	**FY '01** **60**	**Actual FY '99 PM** **39**

Narrative: An annual newborn hearing screening survey has been administered by CSHS to monitor the status of this performance measure. The percent of newborns screened did not change between FY '98 and '99. Out of 32 birthing hospitals surveyed in FY '99, three reported conducting universal screening while three others reporting screening high-risk infants only. Many facilities indicated that a major obstacle to operating a screening program was the cost to purchase equipment and run the program. The percentage of newborns screened will likely increase dramatically over the next three years with receipt of grant funding to support universal newborn hearing screening effective April 2000.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
During FY '99, CSHS will develop a process to monitor newborn hearing screening services.	CSHS staff will develop a survey instrument.	Accomplished. A newborn hearing screening survey was developed during FY '99 to help CSHS more effectively monitor status of screening being conducted in the state. To help assure quality in design of the instrument, a survey from the National Center for Hearing Assessment and Management (NCHAM) was reviewed. Appropriate questions from the NCHAM survey were included in the ND instrument. In addition, staff from the DHS Research and Statistics Unit made recommendations for improvement. The survey was mailed to ND's 32 birthing hospitals in February 1999 requesting data for 1998 births. Based on responses to the survey, 39% of newborns were screened for hearing impairment prior to hospital discharge. A CSHS staff member continued to function as the state hearing contact. During the year, CSHS developed a statewide mailing list of newborn hearing screening contacts.

Type: C **Category: IB** **X Federal State**	**Performance Measure #11:** Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care. **Healthy People 2000 Objective:**				
Actual FY '98 PM **85**	**Projected PM:**	**FY '99** **87**	**FY '00** **87**	**FY '01** **87**	**Actual FY '99 PM** **86**

Narrative: The percent of CSHCNs with a source of insurance in ND has not changed significantly over the last three years. In FY '99, 86% of CSHCN is served by CSHS had a source of insurance compared to 85% in 1998 and 86% in 1997. Based on CSHS program data, the percent of uninsured CSHCNs is higher than that of the child population generally. According to the 1998 Robert Wood Johnson Foundation survey, 8.3% of children in ND were without health insurance. Targets for this performance measure are intentionally flat despite implementation of the CHIP program. Significant changes are not expected for the CSHCN population because CHIP (phase two) only covers uninsured children in families with net incomes at 140% of the federal poverty level.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
During FY '99, CSHS will develop a method to monitor insurance status of CSHCNs.	Include questions regarding insurance status and covered benefits in CSHS family survey.	Accomplished. A comprehensive family needs assessment survey was conducted in 1999 which incorporated questions about health care costs and financing, including concerns with Medicaid and private health insurance coverage for CSHCNs. Survey data was collected for the 2001 Title V needs assessment and disseminated for use in the Title V planning and prioritization process.
	Collaborate with other programs that provide insurance to uninsured children such as CHIP or the Caring Program.	CSHS collects, compiles, and summarizes data about sources of health care coverage for CSHCNs directly served by the program on an annual basis. During FY '99, CSHS collaborated with Medicaid in disseminating CHIP outreach materials to approximately 250 uninsured CSHCNs. CSHS staff also attended training to prepare for phase two implementation of the ND CHIP Program effective October 1, 1999.

Type: C **Category: IB** **X Federal State**	**Performance Measure #12:** Percent of children without health insurance. **Healthy People 2000 Objective:**					
Actual CY '97 PM **8.7**	**Projected PM:**	**CY '98** **9.6**	**CY '99** **9.4**	**CY '00** **9.2**	**CY '01** **9.0**	**Actual CY '98 PM** **8.3**

Narrative: The 1998 data does not reflect enrollment into CHIP. This objective should become obtainable as CHIP is implemented. Legislation pertaining to the ND Healthy Steps (SCHIP) was closely monitored and information provided upon request. Enrollment in CHIP will not begin until 10/99. Projections for this objective will be revised in the FY '01 application.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Increase number of children covered by health insurance.	Research CHIP information and provide to involved agencies.	MCH has kept abreast of developments in CHIP, promoted the ND Healthy Steps (CHIP) program and informed their local partners about the program. In 8/99 a statewide meeting was held to address access to health care with emphasis on the Native American population.
Monitor children covered by health insurance.	RWJF survey completed and analyzed.	MCH was involved in the development of the Robert Wood Johnson CHIP outreach grant. There are two pilot sites in the state: 1) farm families and communities and 2) two Native American reservations.

Type: P **Category: IB** **X Federal State**	**Performance Measure #13:** Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. **Healthy People 2000 Objective:**					
Actual CY '97 PM **81**	**Projected PM:**	**CY '98** **71**	**CY '99** **72**	**FY '00** **73**	**FY '01** **74**	**Actual CY '98 PM** **97**

Narrative: This objective was not only met but exceeded. With additional providers conducting screening/services along with requirements of TANF, more children are receiving these services. Performance Measure projections will be revised.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Continue to work as liaison between local agencies and Medicaid and encourage outreach activities.	Discuss Medicaid provider status at quarterly LHD meetings.	Medicaid has been discussed meetings of local health department administrator and director of nurses.

	Update reimbursement schedules as needed. Encourage participation in ND Health Tracks training/meeting(s). Cooperative MOA between two agencies.	Dialogue is underway regarding reimbursement to local agencies as Medicaid providers. MCH staff attended and participated in Medicaid's Health Tracks (EPSDT) annual all-staff meeting. Medicaid is signatory to the multi-agency memorandum of agreement.

Type: P **Category: IB** **X Federal State**	**Performance Measure #14:** The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. **Healthy People 2000 Objective:** 17.20				
Actual FY '98 PM **10**	**Projected PM:**	**FY '99** **11**	**FY '00** **12**	**FY '01** **13**	**Actual FY '99 PM** **11**

Narrative: Family participation in program and policy activities is primarily assured through support of a CSHS Family Advisory Council. Members of the council assist the division in rating this measure. The rating increased from 10 in FY '98 to 11 in '99, which met the established target. A workable strategy to enhance overall participation has been to target areas of improvement on an annual basis. Title V also supports family participation in the early intervention system.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
By September 30, 1999, CSHS will involve families in the CSHCN elements of the FY '00 MCH Block Grant Application Process.	CSHS review, evaluation and incorporation of CSHS Family Advisory recommendations. Assure family participation in planning	Accomplished. CSHS Family Advisory Council members were given a copy of the Family Voices *Action Plan* for use in reviewing a draft of the FY '00 MCH Block Grant Application. CSHS offered a paid stipend that allowed a CSHS Family Advisory Council member to attend the MCH Block Grant training in San Francisco and CSHS/SSDI provided travel reimbursement that allowed a Family Advisory Council member to attend the AMCHP meeting in Washington. These meetings were a means by which families could gain knowledge and skills to evaluate the MCH Block Grant Applications. Family Advisory Council members reviewed

	retreat and development and administration of CSHS family survey.	and provided comment on a family survey carried out as part of the Title V Needs Assessment. Family representatives were included in a Title V planning retreat that was held November 1999.
By September 30, 1999, CSHS will develop a family needs assessment survey.	An assessment instrument will be developed with the help of Family Advisory Council members.	Accomplished. A comprehensive family needs assessment survey instrument was developed during FY '99. CSHS Family Advisory Council members reviewed the draft instrument and revisions were made based on their recommendations. The survey was mailed to 1,692 families with a response rate of 26.4%. DHS Research and Statistics staff collaborated with CSHS in completing the data analysis.
During the FY, CSHS will collaboratively fund a family-to-family network.	Obtain proposal for the network and initiate contract to provide funding.	Accomplished. Contract funds were provided from the CSHS division and the SSDI Grant to partially fund the development of a statewide family-to-family support network. Early Intervention funds also supported the program. Activities completed during the year included: • Veteran parent training (regional) • Family reunion workshop • Recruitment of regional coordinators • Quarterly newsletter • Web page • Promotional activities (media campaign, video) • Family matches (39 total)

Type: RF Category: IB X Federal State	**Performance Measure #15:** Percent of very low birth weight live births. **Healthy People 2000 Objective:** 14.15				
Actual CY '97 PM	**Projected PM:**	**CY '98**	**CY '99**	**CY '00**	**CY '01**	**Actual CY '98 PM**
1		**1**	**1**	**1**	**1**	**1**

Narrative: The MCH Division will continue to provide state level direction for the local Optimal Pregnancy Outcome Program (OPOP). The OPOP sites will continue to provide quality prenatal education, counseling and referral to maintain the current percentage of low birth weight live births.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Provide supplemental nursing, nutrition and social services to high-risk pregnant women though the Optimal Pregnancy Outcome Program.	Provide partial funding of OPOP activities. Coordinate statewide meetings of OPOP directors and staff. Expand educational section of OPOP policy and procedure manual. Implement new computerized data program in majority of OPOP programs.	Nine local public health departments USED MCH funds for OPOP. Two meetings were held this year for OPOP staff. A draft was started for the last section (Education/Referral/Counseling) of the manual. The new computer data program was implemented January 1999. A Computer manual was developed for use with the computer data program. Drafts for Educational Fact Sheets developed. Biennial Site visits made to specific OPOP sites.
Monitor the rate of low-birthrate live births.	An MCH work group will obtain and review the very low birth weight statistics for the state and identify areas of state with higher rates.	This activity was part of the 5-year needs assessment activities.

Type: RF Category: IB X Federal State	Performance Measure #16: The rate (per 100,000) of suicide deaths among youths ages 15-19. Healthy People 2000 Objective:				
Actual Running Average for CY '95-'97 PM 22.1	**Projected PM:**	**CY '96-'98 27.5**	**CY '97-'99 26**	**CY '98-'00 25**	**CY '99-'01 25**	**Actual Running Average for CY '96-'98 PM 19.9**

Narrative: Adolescent suicide prevention was a priority for the Injury Prevention Program. The Task Force was comprised of individuals, agencies and organizations from throughout the state, including Native American and adolescents. Meetings were held frequently to develop the State Plan, with MCH playing the lead role in coordinating the Task Force and plan. EMSC will provide funds to print and distribute the plan. A grant was written to and funded by the State Children's Services Coordinating Committee to conduct regional and local training with the ND Mental Health Association as the grant recipient.

Annual Performance Objective(s): 10/01/98-9/30/99	Workplan Activities:	Status/Measurement:
Expand involvement of the Injury Prevention Program in youth suicide prevention.	Review and compile data from Vital Records, Youth Risk Behavior Survey and Child Fatality Review Panel to assess completed suicides and suicide attempts.	The Injury Prevention Program coordinated with EMSC to establish a statewide Suicide Prevention Task Force that was chaired by the Lt. Governor. The purpose of the Task Force was to develop a State Plan for Adolescent Suicide Prevention. Data from different sources was reviewed and included in the State Plan, which is currently in draft form.
	Develop a tool for the Child Fatality Review Panel to use to collect additional information on completed suicides.	The tool was not developed this year, but is listed as an activity in the State Plan.
	Participate in Bismarck-Mandan Youth Suicide Prevention Task Force covering a 10-county region. Provide assistance to other local task forces as requested.	MCH staff participated in the ND D/ART organization and promoted awareness of depression by having mental health professionals address WIC and MCH staff in addition to local public health nurses. At least one public health department is now screening clients for depression. Staff attended meetings of the Bismarck-Mandan Task Force.
	Include suicide as a topic in the state Injury Prevention Conference scheduled	Speakers on suicide prevention provided the keynote address at the state Injury Prevention

	for November 1998.	Conference.

Type: RF **Category: IB** **X Federal State**	**Performance Measure #17:** Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. **Healthy People 2000 Objective:** 14.14					
Actual CY '97 PM	**Projected PM:**	**FY '98**	**FY '99**	**FY '00**	**FY '01**	**Actual CY '98 PM**
52.6		**53**	**54**	**55**	**56**	**60.2**

Narrative: The MCH Division will continue to monitor this performance measure since we have little impact on referring practices of private practitioners.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Monitor the percent of low birth weight infants delivered in hospitals with Neonatal Intensive Care Units (NICU).	Review vital records report of births by facility.	Completed.

Type: RF **Category: IB** **X Federal State**	**Performance Measure #18:** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. **Healthy People 2000 Objective:** 14.11					
Actual CY '97 PM	**Projected PM:**	**CY '98**	**CY '99**	**CY '00**	**CY '01**	**Actual CY '98 PM**
84		**85**	**85.5**	**86**	**86.5**	**85**

Narrative: The Optimal Pregnancy Outcome Program continues to provide supplemental educational/counseling/referral services for pregnant women. A new computer data program was implemented January 1, 1999 in OPOP to enhance pregnancy related data collection. Activities directed towards meeting the health needs of women in the state have increased. The current FPP Director has assumed the role of Women's Health Coordinator for ND. A multi-disciplinary, multi-agency committee has been organized to share information, learn more about each other's programs, and address issues such as filling gaps and preventing duplication. The state coordinator has worked closely with the regional Women's Health Coordinator in Denver. MCH staff participated in planning and attending a statewide Women's Health…Women's Lives Conference as well as a statewide Women's Healthful Aging Summit.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Continue support of Native American prenatal programs.	Provide funding for: The Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care	The Spirit Lake Program received $61,720.00 to support an advanced practice nurse working

	and immunizations. The Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination. Three Affiliated Tribes WIC Program to coordinate WIC, Healthy Start and Indian Health Services prenatal activities.	in maternal and infant related activities. The Trenton Indian Health Center received $10,000.00 to enhance their Healthy Start Program. The Three Affiliated Tribes WIC Program received $16,720.00 to provide nutrition services for infants and children not enrolled in the WIC Program.
Continue support of Healthy Start Program.	Participate in Healthy Start consortium meetings. Include Healthy Start staff in MCH sponsored conferences and training events.	The WIC/MCH Nutrition Services Coordinator represented Title V on the Healthy Start in ND, Inc. ND Healthy Start staff was kept informed of training opportunities offered by Title V and other MCH programs.
Conduct New Mothers' Survey to determine reasons for not obtaining early prenatal care.	Revise previous survey questionnaire. Conduct survey. Have data entered into computer and matched with birth records.	Survey was completed. "Didn't know I was pregnant" continues to be a significant reason for not obtaining early prenatal care along with "no insurance or money." These two reasons were highest in the low-income population (WIC participants).

Type: RF **Category: IB** **Federal X State**	**Performance Measure # S1:** The percent of children impacted by a CSCC funded community grant whose focus is categorized as "health" by the grantee. **Healthy People 2000 Objective:** 17.20

Actual FY '98 PM	**Projected PM:**	**FY '98**	**FY '99**	**FY '00**	**FY '01**	**Actual FY '99 PM**
39		**27**	**28**	**29**	**30**	**57**

Narrative: Regional and Tribal Children's Services Coordinating Committees are asked to report on the number of children impacted by CSCC funded community grants whose primary focus is "health." The same categories have been used as a guide to define what constitutes "health" grants each year this measure has been tracked. The established performance target was exceeded in FY '98. Increases can likely be attributed to a strong public health presence on select R/TCSCC boards or an increased awareness of the benefits of prevention and early intervention.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
By September 30, 1999, improve	Promote and document use of	Accomplished.

community capacity to conduct needs assessments for CSHCNs and their families.	assessment models and resource materials applicable to community assessment of the CSHCN population.	Regional and Tribal Children's Services Coordinating Committees (R/TCSCC) update their community assessments annually. To promote assessment of the CSHCN population, coordinators received the 1999 edition of the CSHS Library Catalog. This publication listed numerous resources available for loan that would support the community needs assessment process. During the year, some R/TCSCC's began requiring outcome measures for community grant awards.
	Provide financial and technical assistance through SSDI as needed.	Phone consultation was provided on performance measurement and data sources to track regional outcomes. During FY '99, SSDI funds were used to fund 8 grants to community agencies and service providers to support SSDI objectives.
	Define population-based indicators for CSHCNs and their families.	Meetings were facilitated to discuss quality indicators for the MCH population. Summary material on MCH performance measures was subsequently written and then reviewed by select public health, R/TCSCC and county staff.
During FY '99, provide CSHS administrative support for implementation of SSDI grant objectives at the state and community level.	Continue responsibilities as SSDI Project Director.	Accomplished. CSHS Deputy Director continued as SSDI Project Director with responsibility for supervision of the SSDI Coordinator. The SSDI grant was approved and collaboratively administered by CSHS and MCH divisions.
	Provide technical assistance to State, Regional, and Tribal CSCCs on CSHCN issues.	SSDI coordinator provided assistance to the State CSCC as well as R/TCSCC's. Success was reflected by the increased focus on Title V priorities at the community level demonstrated by an increased percentage of CSCC health grants.

Type: P Category: ES Federal X State	**Performance Measure #S2:** The percent of children with special health care needs who are receiving care coordination services by CSHS. **Healthy People 2000 Objective:** 17.20				
Actual FY '98 PM	**Projected PM:**	**FY '99**	**FY '00**	**FY '01**	**Actual FY '99 PM**
5.2		**5.3**	**5.4**	**5.5**	**5.3**

Narrative: The goal to increase the percent of CSHCNs who receive care coordination services by CSHS was achieved in FY '99; however, changes have been very incremental due to the lack of additional financial support. Future efforts within the division will focus on roles of public health and county social service care coordination staff.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
By September 30, 1999, CSHS will expand the care coordination program.	Explore Medicaid funding for current projects. Request legislative support for additional funds.	Accomplished. Results of an extensive literature review on care coordination outcomes and a cost analysis of Medicaid-eligible children served through public health care coordination programs were shared with Medicaid staff at meetings arranged to discuss care coordination reimbursement. Reimbursement was not obtained. The two care coordination projects originally included in the budget for the 1999-2001 biennium were funded. An optional budget request that would have allowed expansion to at least one additional site was submitted but not approved. The two functioning care coordination projects did expand services. One site increased its service area from a single county to a 4 county region while the other expanded age groups served through the program.
By September 30, 1999, CSHS will evaluate the care coordination program.	Establish efficiency/effectiveness goals that are meshed within the contracting process.	Accomplished. Efficiency and effectiveness goals were included in the care coordination contracts for the period 7/1/99 through 6/30/2000. Included

	Conduct a family and public health satisfaction survey.	were the following: • 50% of FTE time for direct services • Expansion of age groups served (birth to 21) • Unduplicated caseload of 30 children annually per 0.5 FTE • Compliance with care coordination standards Quarterly and annual reports provided by CSHS document achievements and provide a source of feedback for local staff implementing the program. In January of 1999, a provider survey was conducted to assess satisfaction with the care coordination program. Suggestions to improve the program were incorporated into the care coordination standards for the following year. Surveys provided to families by local care coordination staff were not returned.
Through September 30, 1999, CSHS will continue collaborative efforts to enhance care coordination services and provide support for service providers.	Training and technical assistance.	Accomplished. Technical assistance is provided on an ongoing basis to local staff by telephone, E-mail or site visits. Two training opportunities for state and local staff were supported, including attendance at a Care Coordination Institute in Minnesota.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S3:** The rate of abuse and neglect in infants and children from birth to age five. **Healthy People 2000 Objective:** 7.4 (Children under 18)

Actual CY '97 PM	**Projected PM:**	**CY '98**	**FY '99**	**FY '00**	**FY '01**	**Actual CY '98 PM**
6.1		**6.05**	**6.0**	**5.95**	**5.9**	**6.8**

Narrative: Several state and local preventive health activities impact parenting/family issues and may have contributed to reduced child abuse and neglect. The 1996 law change for the definition of a victim may have affected the data for the number of abuse victims. This law change may have contributed to the increased rate. The MCH Division Director is a member of the state Child Protection Team, which addresses reports of abuse or neglect in state institutions housing children. MCH Staff was also involved in a state plan to address sexual abuse prevention in the state.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Develop a plan to evaluate the use of the "Guidelines for Infant and Early Childhood Home Visiting" and determine future needs.	Develop a survey tool to assess the use of the "Guidelines for Infant and Early Childhood Home Visiting" and the future needs of those agencies participating in home visit activities.	Accomplished. Survey tool developed.
Continue to provide technical assistance and consultation to home visit agencies.	Continue mailings of home visit information and funding possibilities. Develop quality assurance indicators.	Accomplished. Mailings of home visit and funding information sent. MCH participated in the 1999 Children's Conference sponsored by the DHS Child Prevention Program. CEUs for nurses were obtained to encourage nurses involved in home visiting to attend. Quality Assurance indicators developed
Continue distribution of the ***Parenting the First Year*** newsletter to parents of all newborns.	Review and revise ***Parenting the First Year*** newsletter using the expertise of MCH and other Health Dept. staff.	Accomplished. Under the direction of ND State University (NDSU) Extension, the review was conducted. Since NDSU Extension discontinued funding this project, the ND Nurses Association became a partner in the project. ***Parenting the First Year*** newsletter was reviewed, revised and distributed.
Follow-up activities completed for April 1998 Infant Massage	Complete follow-up reports to agencies providing funding for the April 1998 Infant Massage	Accomplished. Follow-up reports sent to agencies providing funding for the training.

Instructor Certification Training.	Instructor Certification Training. Prepare the 6-month Post Infant Massage Instructor Certification Training survey.	Accomplished. A Post Training Evaluation Survey was sent to all participants of the April 1998 training.
Finalize the Newborn Postpartum Care section of the Child Health Services manual.	The Forms committee will continue to meet on a regular basis to develop and finalize the guidelines.	Accomplished. The Newborn Postpartum Care section of the Child Health Services manual was finalized.
Continue to provide NCAST information to local public health units and other agencies.	Meet with Terri Busch to develop a plan for NCAST training.	Accomplished. Plan developed to provide NCAST training to health professionals. NCAST training held February 23-25, 1999 and March 23-25, 1999 and re-testing of students who did not pass was completed.
During FY '99, CSHS staff will coordinate with MCH to increase availability of home visiting services.	CSHS staff will actively participate on the home visiting committee.	Accomplished. CSHS staff participated on the home visiting committee and helped complete planned work activities.
Increase the number of parents of newborns who received information on Shaken Baby Syndrome (SBS) from a health professional.	Coordinate a statewide prevention campaign using a multi-faceted task force.	71% of the parents surveyed in the New Mothers' Survey (1999) indicated they received information on shaken baby syndrome from their health care professional. This is a 20% increase since the 1996 New Mothers' Survey.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S4:** Incidence of normal weight among young adults 20-29 years of age (normal weight = BMI of 20-24.9). **Healthy People 2000 Objective:** 2.3

Actual CY '97 PM	**Projected PM:**	**CY '98**	**FY '99**	**FY '00**	**FY '01**	**Actual CY '99 PM**
44%		**45**	**46**	**47**	**48**	**44.5%**

Narrative: The performance measure was met. This past year, more information on physical activity intervention was shared with the local nutritionists. Information on the increase in obesity in the WIC population (both white & Native America) was shared with local nutritionists **and** other interested persons. The findings of the WIC Physical Activity survey were useful to a variety of programs. In addition to the activities below, three focus groups were conducted with WIC parents to discuss issues of TV viewing and physical activity for their three- to four-year-olds. Several useful points were identified that will be explored in future initiatives or educational efforts. Our emphasis for this performance measure is on prevention of obesity in children.

Annual Performance Objective(s): 10/1/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Fund and provide technical assistance for nutrition programs in local agencies.	MCH state nutrition staff will coordinate meetings/conference calls with local MCH nutritionists and other state staff (chronic disease nutrition/5-A-Day and Department of Public Instruction child nutrition programs). Information about current nutrition issues and projects distributed.	Completed. Local nutritionists in over 20 local agencies participated in MCH nutrition activities. Two face-to-face and on conference call were held during the year. Email was used extensively to disseminate materials and program information in a timely bases. More information on physical activity interventions was shared with the local nutritionists.
During FY '99, strengthen the community-based approach for local agency nutrition services.	Promote the population bases community nutrition interventions such as: 5-A-Day; 5-Plus-5; No Body's Perfect; Nutrition Carnival; Young People's Healthy Heart Curriculum, Food Pyramid Lesson Plans.	Completed. At the September 1999 meeting of the local nutritionists decided they want to work together on a state "calcium project" in FY '01 or '02, in addition to continuing 5-A-Day and 5-Plus-5 activities. The MCH Nutritionists made a presentation to Local Public Health Administrators on the 10 Essential Function as they relate to nutrition.
Disseminate results of FY '98 WIC Activity Survey	Complete the analysis of findings. Present findings to WIC staff. Consider adding one or more physical activity assessment questions to WIC certification form Begin development of educational piece based on results of survey	Completed: Results of the physical activity survey were disseminated through the WIC 1998 Annual report. WIC will add any physical activity question that CDC is recommending for their new PedNSS system, but this will not occur until 2001 or 2002. In the meantime, another survey will be conducted in the fall of 2000, so progress in reducing physical inactivity can be charted. The data is also part of the ND Healthy Heart Surveillance report. We plan to repeat a similar survey in the fall of 2000. A WIC monthly nutrition education packet on Physical activity was developed. Because the MCH nutritionist attended the CDC AIM 30

		Physical Activity Conference in the fall of 1999, more information was available to share with local nutritionists and other interested persons.

Type: P **Category: IB** **Federal X State**	**Performance Measure #S5:** Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services. **Healthy People 2000 Objective:** No Related Objective.

Actual CY '98 PM	**Projected PM:**	**CY '99**	**CY '00**	**CY '01**	**Actual CY '99 PM**
32.8		**33**	**33.5**	**34**	**36.7**

Narrative: We continue slow but steady progress in improving access to dental care for Medicaid-eligible children. We exceeded our CY '99 target by 3.7%. A Medicaid Workgroup promotes interagency collaboration with private sector providers to better understand issues and develop strategies for change. During the 1999 Legislative Session, two significant bills passed that will improve access to dental care for low-income families. Dental care was included in the Phase II CHIP plan (Healthy Steps) benefit package and legislation passed mandating medical insurance policies to include coverage for hospitalization and general anesthesia for young children with severe dental caries, the disabled, and children with special health conditions that require hospitalization for care. The Oral Health Program staff developed new educational materials promoting parental responsibility for dental care. The Red River Dental Access Committee received significant support to develop a strategic plan to improve dental access in eastern ND. Local public health departments provided screening for the Medicaid Health Tracks Program (EPSDT) and continue work to improve referral systems.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Identify and investigate issues relating to access to care for Medicaid clients.	Form Medicaid workgroup and hold periodic meetings.	A dental Medicaid workgroup was formed and met in October 1998 to determine data needs for the 1999 legislative session. The Oral Health Program and the ND Dental Association collaborated on a study to determine workforce needs for the next decade. The study showed 40% of dentists plan to retire in the next ten years. Recruitment and retention or dentists will be a major issue in the future.
	Collect and analyze primary and secondary data and report findings.	A survey tool was developed to track workforce trends and gather baseline data for dentists, dental hygienists and dental assistants. The Medicaid Program and Oral Health Program developed a provider and client information summary of dental services. The

		Medicaid Director presented the summary at regional dental meetings across the state to encourage providers to participate in the program and gather their input on how the program could be improved. Two policies improving access to dental care passed in the 1999 Legislature. The Medicaid workgroup advocated for the inclusion of dental benefits in the state CHIP plan and Oral Health Program staff presented testimony to the legislature on the potential number of children that would benefit from insurance coverage for hospitalization/anesthesia for dental care. Both policies will expand dental coverage for low-income families.
Increase capacity of the Fargo Family HealthCare Center to treat Medicaid clients.	Assist Community Health Center in obtaining additional resources to provide dental care.	The Oral Health Program provided technical assistance and consultation to the Red River Valley Dental Access Project. A bi-state (Minnesota, North Dakota) forum on dental access was held in Fargo in November 1998. The forum provided the impetus to develop a local coalition to improve dental access. The coalition has received over $400,000.00 in grants to develop a community strategic plan, to expand the Family HealthCare dental services to include a satellite clinic in Moorhead, MN and to expand the mobile dental services provided by Apple Tree Dental.
Develop mechanisms to encourage dentists to provide care for Medicaid clients.	Assist local health agencies/communities in developing projects to improve access to care.	The Oral Health Program developed a new initiative "Project Will Show" designed to educate Medicaid parents about their roles and responsibilities regarding their child's dental care. The materials include a video and two brochure/fliers that will be distributed to Head Start, WIC, Health Tracks, and private dental offices to encourage referral agencies to talk to their clients about the importance of preventive

		dental care and appropriate health behaviors. Referral agencies assisted in the development of the materials. Eight local public health departments used MCH funds for BBTD prevention projects and other oral health projects directed towards the maternal and infant populations. Another four local health departments used MCH funds to provide oral health primary preventive services for children and adolescents.

Type: C **Category: DHC** **Federal X State**	**Performance Measure #S6:** Ratio of school nurses to students in ND. **Healthy People 2000 Objective:** 17.20					
Actual FY '98 PM	**Projected PM:**	**FY '99**	**FY '00**	**FY '01**		**Actual FY '99 PM**
.62		**.68**	**.82**	**.95**	**1**	**.18**

Narrative: The goal to have a ratio of one nurse per 1,000 students was not achieved due to lack of financial support. The ratio of nurses to students has not changed significantly over the past three years. A survey conducted last year provided us with statistics showing a ratio of 1 nurse per 5,613 students. The legislative session did not support a bill to provide school nurses. A grant was written to CSCC to obtain funding for nursing services in schools. The grant was not funded. The program assists in the coordination of statewide school nurse meetings for the purpose of program updates and sharing resources. The program provides technical assistance for school health services including scoliosis, vision and hearing, and safety issues for students, teachers and support staff. Closely related to school health are safety and health issues in childcare settings. MCH has been involved in a variety of activities affecting childcare in the state. The division has worked closely with the Child Care Division within the DHS on the Child Health Care Project promoting health and safety issues in childcare settings. This project has employed nurses in the four major ChildCare Resource and Referral agencies. MCH has also collaborated with the state Head Start Coordinator in many health-related areas. MCH participates in the ND Collaboration on Early Childhood Training (NDCONECT) committee. As a member of ND Council on Developmental Disabilities, MCH has encouraged grant funding to Child Care Resource and Referral agencies seeking funds to address needs of children in childcare with special health care needs or disabilities. The MCH Division Director was asked to review and make comment on the new edition of the "Caring for Our Children" manual.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Provide technical assistance to schools and school boards developing school health services programs.	Telephone consultation and written information will be given to schools and school boards inquiring about school health services programs.	Telephone consultation and written information were provided to schools.
Develop standardized data	Collaborate with Department of Public	Collaborated with DPI And HPE to develop a

collection form.	Instruction (DPI) and Health Promotion and Education (HPE) to develop standardized method of reporting services provided in schools.	survey to be included in the SHEP Survey as a standardized means of reporting services provided in schools.
Provide technical assistance to school nurses.	Assist with the coordination of ND School Nurses organization meetings. Share resources with school nurses and local health departments. Survey school nurses needs for training.	Met with new school nurse employed with MCH funds at Fort Yates to explain MCH Division and role of school nurse. Current information on pediculosis shared with school nurses. MCH has acted as liaison with the Optometric Association to collaborate on vision screening. The FAS Task Force with several MCH staff as members provided training to school personnel on dealing with FAS students.
Advocate for school health services provided by a school nurse.	Give presentations to School Administrators meeting, ND Education Association annual meeting and other school-related meetings to promote school-nursing services. Have local school nurses and principals of progressive programs speak at meetings in their surrounding communities. Attend ND School Health Network (NDSHN) semi-annual and Executive NDSHN meetings, advocating for school health services.	The Health Officer, local school nurses and principals gave presentations in their local communities to promote school-nursing services. The State Director of the School Nurse Program attended and participated in the School Health Network semi-annual and executive meetings to advocate for school health services.
Through September 30, 1999, CSHS staff will coordinate with MCH to increase availability of school health services.	CSHS staff will actively participate on the School Health workgroup and continue involvement in the ND School Nurses organization.	Accomplished. CSHS staff actively participated on the state-level school health committee and attended two school nurse meetings.

Type: P **Category: PBS** **Federal X State**	**Performance Measure #S7:** The number of nonfatal injuries requiring hospitalization for children 19 years of age and under reported in the ND Health Care Claims Database. An increase in the use of E-codes by hospitals. **Healthy People 2000 Objective:** 17.20					
Actual FY '98 PM **NA**	**Projected PM:**	**FY '99** **5**	**FY '00** **10**	**FY '01** **20**	**FY '02** **30**	**Actual FY '99 PM** **NA**

Narrative: Because of the uncertainty of the future of the Health Care Claims Database, this measure was not pursued. Instead, the program worked with EMSC to collect injury data from the ambulance trip reports.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Increase use of reports in Health Care Claims database which are E-coded.	Review status of E-coding. Prepare and distribute report of findings. Target larger hospitals and meet with them to encourage E-coding. Monitor throughout year.	EMSC collected data on the number of ambulance trips that involved children. The information was distributed to EMTs and other injury prevention advocates.
Continue serving as ND representative for Consumer Product Safety Commission (CPSC).	Conduct recall effectiveness checks and special projects as assigned by CPSC. Distribute media releases and prepare articles for "Building Blocks to Safety" newsletter regarding product recalls.	Six recall effectiveness checks were conducted following CPSC guidelines. Four issues of the "Building Blocks" were written and distributed.
Continue assisting local health departments, law enforcement agencies and others to develop community-based injury prevention projects.	Provide technical assistance, data, training, and materials to local entities for injury-specific topics, i.e., home safety, poison prevention, playground safety, etc. Coordinate activities with Emergency Medical Services for Children (EMSC) Project, Safe Kids Coalition, Native American Injury Prevention Coalition, etc. Sponsor and coordinate a statewide Injury Prevention Conference.	Eight local health departments utilized MCH funds in injury prevention activities/programs. All public health agencies participated in at least one injury prevention project (Child Passenger Safety Week, high-school seat belt presentations, etc.). The program collaborated with all agencies listed. Conference held November 1998 with approximately 100 participants.

2.5 Progress on Outcome Measures

Because of small population and number of annual events, we have elected to use three-year running averages for all federal outcome measures and the state selected outcome measure. We are using the last year of the three years averaged as the reporting year. Final 1999 Vital Records data is not available at the time of the Application so data reported for FY '98 consists of 1996, 1997, and 1998 data.

OUTCOME MEASURE 1 – The infant mortality rate per 1,000 live births

The ND rate increased slightly from 6.6 in 1997 to 6.7 in 1998. The rate remains significantly below the national rate.

OUTCOME MEASURE 2 – The ratio of Black infant mortality rate to the White infant mortality rate.

The extremely small number of Black births in ND results in unreliable trend data. There were 261 Black births 1996-98 and just one Black infant death during that period.

OUTCOME MEASURE 3 – The neonatal mortality rate per 1,000 live births.

The ND neonatal mortality rate decreased from 4.3 in 1997 to 4.2 in 1998.

OUTCOME MEASURE 4 – The postneonatal mortality rate per 1,000 live births.

The rate in ND increased slightly from 2.2 in 1997 to 2.4 in 1998.

OUTCOME MEASURE 5 – The perinatal mortality rate per 1,000 live births.

The ND rate decreased slightly from 9.8 in 1997 to 9.4 in 1998.

OUTCOME MEASURE 6 – The child death rate per 100,00 children age 1-14.

The ND rate decreased significantly from 40.0 in 1997 to 21.4 in 1998.

Outcome Measure 7 (State Negotiated) – The ratio of Native American infant mortality rate to the White infant mortality rate.

The ratio decreased from 1.9 in 1997 to 1.7 in 1998.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Early in 1999, the ND Title V program began planning the 5-year needs assessment of the Maternal and Child Health Population for the FY '01 MCH Block Grant Application. A workgroup was formed comprised of representatives from the Maternal and Child Health Division in the DoH and the Children's Special Health Services Division in the DHS along with representatives from the ND Primary Care Office/Primary Care Association. Staff from the Vital Records Division, the State Data Coordinator and Chief Medical Officer from the DoH participated in the workgroup. The SSDI Coordinator provided leadership to the needs assessment process and facilitated workgroup meetings.

Initially the workgroup identified five population groups within MCH: 1) women of childbearing age; 2) infants; 3) children; 4) adolescents; and, 5) children with special health care needs. Four need categories were selected: 1) health status; 2) health care utilization; 3) health care access; and, 4) the health care system. These need categories were chosen to correspond with MCHB pyramid levels and reflect the need for direct health care services, enabling services, population-based services and infrastructure building services for the maternal and child health population.

A number of need indicators were selected for each population group and each indicator category and data was collected for each. Efforts were made to collect multi-year data to identify historical trends, county level data to identify geographic disparities, national data as a comparison to state level data, and data on the state's Native American population to identify racial health disparities.

A number of primary and secondary data sources were used for the selected need indicators. Important secondary data sources included state and national vital records, census, and population data. Information from ND's Health Care Claims System and Kids Count data was also collected. In addition, program data was collected from a number of public and private agencies serving the maternal and child health population. Primary data sources included the Youth Risk Behavior Survey, the Behavioral Risk Factor Surveillance System, a New Mothers' Survey conducted by the MCH Division and a Family Survey conducted by the CSHS Division. National survey results, such as the National Health Interview Survey on Disability, were used to calculate state-specific prevalence estimates of chronic health conditions.

State birth and death data from the Vital Records Division in the DoH was collected. Death certificate data was used to assess the number and causes of deaths to children in the state. Birth certificate data was used to assess birth outcomes and maternal risk factors. Data dating back to 1990 was used to identify historical trends. For the first time, we had access to individual birth and death files from 1997 and 1998 to allow for analysis of geographic and racial health disparities. United States birth and death data was also collected from the National Vital Statistics System and compared to State data to assess differences between ND and US rates.

1998 population estimates were obtained from the US Census Bureau in order to track changes in the demographic characteristics of the maternal and child health population from the 1990 Census to the present. North Dakota maintains a health care claims system consisting of inpatient and outpatient hospital visits and ambulatory care visits from claims submitted by payers including Medicaid and several private insurers such as Blue Cross/Blue Shield; the State's largest private insurer. It is estimated that this system captures about 85% of all health care claims in the state. Calendar year 1996 and 1997 data from this system were used to collect information on the leading causes of pediatric hospitalization, the payment source of pediatric hospitalizations, and hospitalization and ambulatory care visits for selected ambulatory sensitive conditions such as asthma, diabetes, epilepsy, depression and ADHD.

Program data were collected from a variety of private and public agencies serving the maternal and child health population. The number of children and demographic characteristics of children

served through the CSHS Division was collected. Diagnostic and insurance status information about CSHCN was also collected from CSHS program data. The Children and Family Services Division in the DHS provided child abuse and neglect reports and foster care data. The Medical Services Division provided eligibility and participation rates in ND Health Tracks, the state's EPSDT program. The Disability Services Division in the DHS and the Special Education program in the Department of Public Instruction provided additional data on children with special health care needs served. The MCH WIC, Oral Health, and Family Planning Programs, plus programs within the Division of Disease Control in the DoH provided program specific data.

Synthetic estimates of the prevalence of chronic health conditions in children were derived from national estimates from the National Health Interview Survey on Disability, Gortmaker estimates, ND Genetics program services and March of Dimes Birth Defects prevalence rates.

In addition to National Kids Count data available through the Annie E. Casey Foundation, North Dakota specific Kids Count data has been published on an annual basis for the past six years. This data was used to identify historical trends and compare national and state data. North Dakota Kids Count provides data by county and region in the state, which helps to identify any geographic differences for many child health and well-being indicators.

Several provider organizations and professional associations were contacted to assess the number of health care professional and related service providers in the state and to determine the geographic location of their practice. The Center for Rural Health at the University of ND, along with the ND Primary Care Office provided data on the availability of health care providers and medically underserved and health professional shortage areas across the state. Much of the county-specific data was graphed using GIS mapping software to assist in identifying geographic disparities for a number of health indicators.

Primary data sources included several statewide surveys. The Youth Risk Behavior Survey is completed biannually and the Behavior Risk Factor Surveillance System Survey annually in ND. The Maternal and Child Health Division has conducted a New Mothers' Survey in 1996 and 1999. This survey contains many of the same components of the PRAMS survey and asked respondents a variety of questions about pre-pregnancy behaviors, access to prenatal care, the educational content of prenatal visits, pregnancy and stress, access to health care and education about infant care.

In 1999 the CSHS Division conducted a statewide survey of all children directly served by the State CSHCN program. The survey asked parents of CSHCN a variety of questions about their child's health status, health care utilization, access to health care and financing and family impact issues. This comprehensive survey was the primary source of data for several federal performance measures and provided information about the health and related needs of children with special health care needs and their families.

Specific Title V staff from MCH and CSHS were assigned primary responsibility for each MCH population group. These staff reviewed and analyzed available data for selected indicators and identified 5-7 priority needs for each population group. Data on these priority needs were presented to 30-40 participants at a planing retreat held in November 1999. Retreat participants included representative from the state Departments of Human Services and Health, Head Start, EPSDT, local public health departments, county social service agencies, the Primary Care Association, special education, and CSHS and MCH advisory councils. A facilitator led attendees through a prioritization process using the PEARL method in which each priority need was ranked based on a number of objective and subjective criteria. A copy of the worksheet used to determine priority needs is included as a supporting document in Section 5.3.

The Title V workgroup met following the retreat to reach consensus about the priority needs identified at the retreat and the priority ranking established. Twenty-six priority needs were identified. The workgroup then identified which priority needs were addressed through goals and objectives for

existing federal performance measures and those that were not. For those that were, the priority need was addressed with specific activities designed to impact the priority need. Workgroup members then proposed state negotiated performance measures for those priority needs that were not determined to be addressed in federal measures.

In addition to feedback from retreat participants, families and other constituents were involved throughout the needs assessment process. The CSHS Division maintains regular contact with the State Family Voices representative and other parent groups in the State. The CSHS Family Advisory Council received training and information on Title V and the MCH Block Grant Application process. They provided recommendations on CSHS priority needs and suggested interventions that were incorporated into the Annual Plan. The MCH Advisory Committee also provided input on priority needs for the maternal, infant and child populations. Consensus on the overall state priorities and state negotiated measures was reached in mid-April 2000.

The results of the needs assessment and prioritization process provided the framework for the development of the Annual Plan. Specific CSHS and MCH staff persons were assigned responsibility for each federal performance measure. Each staff person developed goals, objectives, workplan activities and evaluation measures for each measure along with target projections. The same process was followed for the state-negotiated measures. CSHS and MCH staff members identified related Healthy People 2010 objectives and annual targets, developed work plans to impact the measure, and identified data sources to track progress and improvement for the measure. After a draft Annual Plan was completed it was reviewed by all Title V staff prior to inclusion in the Application.

Several limitations were identified in the data collection and analysis process for the needs assessment. At present there is no electronic data system in the State Title V program. Most data was collected, organized, copied and shared with Title V staff manually. Title V staff was also limited in their capacity to provide detailed analysis to the data. Several local agencies and service providers conduct needs assessments for the maternal and child health population at the community level. Local public health departments, Regional and Tribal Children's Services Coordinating Committees, and private health care providers all assess the needs of selected populations at a local level. The State Title V Program has not been able to effectively incorporate these community needs assessment into the statewide needs assessment process.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

North Dakota's population continues to decrease and become older. The same is true for the maternal and child health population. According to 1990 US Census Bureau data and 1998 population estimates, the number of children and the number of women of child bearing age in ND declined between 1990 and 1998. The maternal and child health population is predominately White with the largest minority population being Native American. Between 1990 and 1998, the White MCH population declined and the state's minority population increased. The greatest increase was in the Asian and Hispanic populations.

Children Age 0-19	1990	1998	% Change
All Children	196,120	181,154	-- 7.4
White Children	178,696	163,109	-- 8.7
Minority Children	17,377	20,992	+ 20.8
Children Age 0-9	100,377	82,466	-- 17.8

Children Age 10-19	95,743	101,688	+ 6.2
Women Age 20-44	**1990**	**1998**	**% Change**
All Women	117,435	110,268	-- 6.1
White Women	109,959	101,927	-- 7.3
Minority Women	7,476	8,692	+ 16.3
Women 20-34	73,981	62,246	-- 15.9
Women 35-44	43,454	48,022	+ 10.5

Most of the available socioeconomic data for the maternal and child health population was from the 1990 Census, so current poverty level information was not available. According to 1995 US Census Bureau estimates, 11.9% of the state's overall population was below 100% of the federal poverty level. In 1995, 15.9% of children under age 18 were below 100% of the poverty level. 16.4% of children under age 5 and 14.7% of children between the ages of 5 and 17 were living below the federal poverty level. The number of children on TANF, the state's Welfare Reform program, declined from 15,850 in 1995 to 12,190 in 1998. The number of White children on TANF declined by about 40%; from 8,957 to 5,399 but the number of Native American children on TANF decreased only slightly from 6,167 in 1995 to 6,074 in 1998.

The following sections describe the health status of pregnant women, mothers and infants, children and adolescents, and children with special health care needs in ND. Data for most of the selected need indicators is summarized and when available, data for the 5-year period 1994 through 1998 were compared. There were some indicators in which the rates worsened and some that improved. Generally, the MCH population in ND compares favorable to the population nationally. There are substantial racial disparities between the White and Native American MCH populations in ND. However, other than some vital record data, we lack adequate data to substantiate these disparities.

Pregnant Women, Mothers, and Infants:

Resident live births in ND have declined from 8,585 in 1994 to 7,930 in 1998. The birth rate in ND has declined from 13.4 in 1994 to 12.4 in 1998 compared to 14.6 for the US in 1998. The fertility rate in ND declined from 69.9 in 1994 to 58.3 in 1998 compared to 65.0 for the US in 1998.

Infant mortality rates, neonatal death rates and fetal death rates in ND have all increased between 1994 and 1998 but remain below national rates.

		1994	**1995**	**1996**	**1997**	**1998**
Infant Mortality Rates	North Dakota	7.2	7.2	5.3	6.2	8.6
	United States	8.0	7.6	7.3	7.1	
Neonatal Death Rates	North Dakota	5.1	4.1	3.7	3.6	5.4
	United States	5.1	4.9	4.8	4.7	
Fetal Death Rates	North Dakota	5.6	7.9	5.0	5.3	6.2
	United States	7.0	7.0	6.9		

The leading causes of infant death in ND between 1994 and 1998 were perinatal conditions (108) and congenital anomalies (90). In ND, for the period 1994-98, congenital anomalies accounted for 29% of infant deaths compared to 22% for the US in 1998.

The percent of babies born low birth weight (LBW) and very low birth weight (VLBW) in ND has increased between 1994 and 1998 but is still less than the US percent. For this 5-year time period, the percent of low birth weight and very low birth weight babies born to Native American mothers decreased in ND while the percent for White mothers increased.

Percent Low Birth Weight Births	1994	1995	1996	1997	1998
North Dakota	5.4	5.3	5.7	6.2	6.5
United States	7.3	7.3	7.4	7.5	
ND White Mothers	5.2	5.1	5.7	6.0	6.5
ND Native American Mothers	6.5	5.1	5.8	7.4	5.9
Percent Very Low Birth Weight Births	**1994**	**1995**	**1996**	**1997**	**1998**
North Dakota	1.0	1.0	0.9	1.1	1.4
United States	1.3	1.4	1.4	1.4	
ND White Mothers	0.9	0.9	0.8	1.2	1.4
ND Native American Mothers	1.5	1.3	1.2	1.1	1.1

The number of babies born with a metabolic disorder identified through the Newborn Metabolic Screening program remained constant at 4 to 5 births per year. Breast feeding rates statewide and within the WIC population both at the initial newborn screening and at six months have increased between 1994 and 1998. Breast feeding rates for Native American mothers are lower than for White mothers but there has been greater improvement among Native American mothers during this period than for White mothers. According to the New Mothers' Survey, 91% of mothers reported they placed their baby to sleep on his or her back or side in 1999 compared to 78% in the 1996 survey.

The percent of mothers who received prenatal care in the first trimester increased from 83.5% in 1996 to 85% in 1998. This is higher than the national percent of 83% in 1998. Prenatal care adequacy, as measured by the Kotelchuck Index, increased statewide in ND from 65.0% in 1994 to 68.9% in 1998. In 1998, the percent for Native Americans was 54.1% and the percent for White 70.8%.

According to Vital Records data, the percent of babies born with one or more risk factors increased from 18.3% in 1994 to 22.3% in 1998. Multiple births increased from 2.7% of all births in 1994 to 3.0 % in 1998. In 1998, 3.8% of Native American mothers reporting using alcohol during their pregnancy compared to 0.8% for White mothers. The percent of ND mothers who reported using tobacco during pregnancy in 1997 was 19.9% compared to 13.2% for the US. The rate was more than double for the Native American population (39.8%) than for the White population (17.0%).

Percent Used Tobacco During Pregnancy	1994	1995	1996	1997	1998
All Mothers	19.3	17.7	18.3	19.9	19.4
White Mothers	17.1	15.8	16.0	17.4	17.0
Native American Mothers	41.8	37.9	39.8	41.8	39.8

Primary cesarean deliveries (first cesareans to women who had no previous cesarean) for 1998 was lower in ND (11.5%) and for the US (14.9%). The VBAC (vaginal birth after pervious cesarean delivery) was higher in ND for 1998 (31.2%) than for the US (26.3%).

According to 1999 New Mothers' Survey results, 61% of pregnancies were intended. The percent was lower for Native American women and women of lower income. The percent of babies born out of wedlock in ND increased from 23% in 1994 to 27% in 1998 but remained lower than the US percent for 1998 of 33%. For ND children born out of wedlock, their mothers were more likely to be Native American, to have used alcohol and tobacco during their pregnancy, have later prenatal care and be born to teenage mothers.

The percent of low-income women reported as overweight was higher than for women overall as reported on the BRFSS. The rate per 100,000 of reported domestic violence cases increased from 218.8 in 1995 to 230.6 in 1996.

Children and Adolescents:

According to 1990 US Census Bureau data and 1995 estimates, the percent of children in poverty decreased from 17.1% in 1990 to 15.9% in 1995. However, for both years, children under age 5 were more likely to be living in poverty than children overall. Children in the state were more likely to be living in poverty than the overall population in the State. 83% of ND children age 0-5 were appropriately immunized compared to 78% of children nationally.

The percent of WIC children age 2 and age 3-4 who are overweight, determined as greater than 95% height/weight, increased from 1994 to 1998 for both White and Native American children. Native American children in both age groups have a higher percent overweight than do White children.

PERCENT OF CHILDREN OVERWEIGHT					
2 Year Old WIC Children	**1994**	**1995**	**1996**	**1997**	**1998**
White	4.1	3.6	3.9	5.0	5.7
Native American	9.4	9.0	8.2	8.1	11.6
3-4 Year Old WIC Children	**1994**	**1995**	**1996**	**1997**	**1998**
White	5.9	5.5	5.8	7.1	6.3
Native American	10.6	11.4	10.7	11.4	11.7

Due to the low child population in ND, the child mortality rate has varied from year to year but has historically remained lower than national rates. However, for the years 1994-96, the child mortality rate for children age 1-4 exceeded the national rate.

The total number of deaths to children age 0-9 increased from 131 in 1997 to 138 in 1998. The leading cause of death for this age group was circulatory diseases. The total number of deaths to children and adolescents age 10-19 also increased from 58 in 1997 to 65 in 1998. Injuries and poisoning were the leading causes of death for this age group.

The death rate due to unintentional injuries for children 1-14 decreased from 1996-1998. For ND children age 10-19, the death rate due to unintentional injuries and suicide, from 1987-1997, was greater than the US rate. From 1992 to 1996, 60 ND children completed suicide. North Dakota has the second highest rate in the United States of suicide for youth age 10-14. Although the ND rates for youth suicide decreased from 1996-1998, North Dakota has the sixth highest suicide rate for teens age 15-19. In ND, the suicide rate for Native American teens is three times the rate for White teens.

Suicide Death Rate (Age 10-14)	**1994**	**1995**	**1996**	**1997**	**1998**
North Dakota	4.1	8.2	8.2	2.0	6.1
United States	1.7	1.7	1.7	1.6	
Suicide Death Rate (Age 15-19)	**1994**	**1995**	**1996**	**1997**	**1998**
North Dakota	12.9	23.6	21.4	27.9	17.1
United States	11.1	10.5	9.7		

The percent of all state births to teen mothers age 10-19 declined from 9.2% of the total in 1994 to 8.0% in 1998. Birth rates for ND teens aged 15-19 were lower than national rates from the years 1994 through 1998.

The number of hospitalizations for children age 0-20 decreased from 11,221 in 1996 to 8,481 in 1997. Excluding newborn delivery and teen pregnancy and childbirth admissions, mental health disorders are the leading cause of hospitalization for children age 6-11, age 12-17, and for children overall. Respiratory diseases, including asthma, are the second leading cause of hospitalizations for children overall.

Access to health care for children is influenced by a number of economic and geographic factors. According to a 1998 Robert Wood Johnson Family Foundation statewide survey, 8.3% of ND children were uninsured. 7.9% of children ages 0-6 were uninsured and 8.6% of children age 7-18. The percent of Native American children who had dental caries and untreated dental caries was higher than for White children in ND.

Participation in various community programs and services is increasing for children and adolescents in ND. This may be reflective of increased needs for children or improved awareness and access to needed services. The number of children participating in the free and reduced school lunch program increased from 27% of children in 1994 to 29% in 1997. The number of children participating in WIC increased 24,296 in 1995 to 27,115 in 1998. However, partially due to Welfare Reform efforts, the percent of children receiving food stamps decreased from 19.4 in 1994 to 17.0 in 1997.

Children with Special Health Care Needs:

Children with special health care needs are served through a number of public programs and services. The number of children age 3-4 enrolled in Head Start increased from 1,682 in 1994 to 2,527 in 1998. Special education enrollment increased from 12,372 students in 1993 to 12,902 in 1998. The eligibility categories with the largest percent of increase were seriously emotionally disturbed, other health impaired, autism and traumatic brain injury.

The number of children served directly through the State CSHCN program increased from 1,523 in 1993 to 1,799 in 1998. The percent of young children age 0-2 served nearly doubled from 9.7% in 1993 to 18.9% in 1998. The percent of children served who were Native American increased from 6.7% in 1993 to 12.0% in 1998.

According to a 1999 hospital survey conducted by the CSHS Division, 39% of newborns are screened for hearing impairment at birth. The estimated number of children in the state with activity limitation due to chronic illness is based on national data from the NHIS-D. Based on 1998 state population estimates for children age 0-19, about 9,000 children in the state experience limitations in activity.

For children served directly through the State CSHCN program in 1999, about 86% had a source of coverage and about 14% were without a known source of coverage. Of the CSHS children with a source of coverage, about 70% had private insurance and about 16% public insurance such as Medicaid. Of the children with out a known source of coverage, about 10% reported having no source of coverage and the insurance status was unknown for about 4%. Trend data from 1997 and 1998 show similar percentages.

Although most children with special health care needs had access to health insurance, often this coverage was not sufficient to meet their needs. According to the 1999 CSHS Family Survey, in addition to co-pays and deductibles, parents reported numerous out-of-pocket expenses including medicine and prescriptions, health care related transportation and long distance telephone calls, wages lost due to time taken off from work, room and board costs for extended hospital stays for their child and costs for the purchase of non-covered medical equipment.

Health care and related services for children with special health care needs in ND is often not well coordinated. Family survey respondents reported a lack of knowledge about community programs and services available to their child and only 14.6% of survey respondents indicated their child and family had a written plan of care.

Initial review of congenital anomaly data seemed to indicate variations in state rates and differences between state rates and national rates. Statistical analysis was performed to determine the significance of these differences. The increase in the rate of congenital anomalies in the state between 1997 and 1998 was found statistically significant at a 95% confidence limit. When 3-year averages were used, the changes were not found to be significant. Overall, when trend data is reviewed, the rate of congenital anomalies in the state is decreasing.

The difference between state and national rates of congenital anomalies overall, and for selected anomalies, was found statistically significant. It is unknown if these differences are due to better identification and reporting in ND than for the United States generally or if actual differences are present. Differences in congenital anomaly rates by county in 1997 and 1998 were not found statistically significant. Male children in ND are statistically more likely to be born with a congenital anomaly than female children. Other demographic differences between children born with a congenital anomaly and those born without in 1997 and 1998 were not found to be statistically significant.

The number of pediatric specialty providers and ancillary providers such as audiologists and occupational, physical, and speech/language therapists increased in the state from 1994 to 1998. Two-thirds to three-fourths of these providers practice in one of four large urban centers in the state. Forty-eight percent (48%) of all ND children and less than 42% of children responding to the CSHS Family Survey live in these urban areas. The location of providers leads to geographic access barriers for many children with special health care needs.

Specialty Care or Related Service Provider	Percent Who Practice in 4 Large Urban Centers	Percent Who Practice in Other 49 Counties
Family Practice Physicians	49%	51%
Psychiatrists	72%	28%
Pediatric Specialists	82%	18%
Dentists	55%	45%
Physical Therapists	70%	30%
Speech/Language Therapists	66%	34%
Audiologists	84%	16%
Respiratory Therapists	73%	27%
Occupational Therapists	75%	25%
Pediatricians	84%	16%

Hospital and outpatient claims data from 1996 and 1997 was reviewed for children with a primary diagnosis of one of five selected ambulatory sensitive conditions: asthma, diabetes, epilepsy, ADHD and depression. Of the five conditions, asthma accounted for the highest percent of all pediatric hospitalizations (1.6%). As a percent of all pediatric hospitalizations, asthma and diabetes increased from 1996 to 1997 and epilepsy, ADHD and depression decreased.

3.1.2.2 Direct Health Care Services

Most primary health care is provided by the private sector in ND. Local public health departments provide little direct medical health care services and there is only one Federally Qualified Health Clinic (FQHC) in the State.

North Dakota has a higher percentage of total physicians who are primary care physicians than does the United States overall and a higher rate of physician assistants and registered nurses, per 100,000 population, than the national rate. However, ND has fewer dentists, per 100,000 population, than the United States overall. The percent of Medicaid eligible children in ND who had a physician visit in 1998 was higher than the national percentage but the percent of Medicaid eligible children who had a dental visit during the year was lower than the US percentage.

Children's Special Health Services directly served 1,749 children during FY '99. 277 children received treatment services and 193 diagnostic services. 275 children were served through contracted services including 42 in two care coordination programs. 1,129 children were served in cleft, scoliosis/orthopedic, cardiac or metabolic clinics statewide.

The number of children in the State receiving Supplemental Security Income (SSI) benefits decreased from 1,776 in 1995 to 1,590 in 1999. The percent of SSI recipients who are Native American remained constant at about 15%. The number of children receiving Health Tracks, the state's EPSDT program, decreased from 34,185 in 1995 to 32,386 in 1998. However, the percent of Health Tracks eligible children who received initial or periodic screenings and who received vision, dental, or hearing assessment increased from 1995 to 1998.

Gap filling services continue to be needed for families with traditional health insurance. Many families that have a source of coverage do not have access to all of the services required by the child and family. Payment for diagnostic and treatment and access to multidisciplinary clinics and specialty programs that provide comprehensive care continues to be a need in the state.

The North Dakota Family Planning Program provided direct services to 14,026 individuals during 1998. These services were provided by ten delegate agencies strategically located in each of the larger cities in the state and covering all eight regions of the state.

3.1.2.3 Enabling Services

Financial access to specialty care and related service providers for children with special health care needs and their families was assessed. It was estimated in 1998 that 8.3% of ND children were uninsured while 11.6% of the children receiving services through the State CSHS program did not have a source of insurance. According to a family survey conducted by the CSHS Division, 35.1% of families said they were not able to pay for all of their child's health care costs and 33.2% said that out-of-pocket health care costs were a financial burden to them. The percent was higher for families below 100% of the federal poverty level.

Only 67% of CSHCN Medicaid recipients and 65.2% with private insurance said their insurance paid for all of their child's health care costs. Nearly one-half of families surveyed (49.8%) reported they had out of pocket health related expenses for medicine or prescriptions for their child and more than one-third (38.4%) reported out of pocket expenses for transportation costs. More than half of the families said they paid at least a portion of the costs for their child's primary care physician and specialist visits and for their child's hospitalizations. Families also reported financial access problems with auxiliary providers such as occupational, physical, and speech/language therapists as well as access to medications, special diets, equipment and supplies.

The availability of specialty care and related service providers was also assessed. Thirty of ND's fifty-three counties are designated Medically Underserved Areas (MUAs) and ten counties are considered Dental Health Professional Shortage Areas (HPSAs). Despite a declining population, ND had slightly more physicians, including General Practitioners and Family Practice Physicians, in 1998 than 1994. There were also more dentists, pediatric specialists, and associated health professionals such as nurses and nurse practitioners.

Most of these health care professionals live and practice in one of four major population centers in the State. 82% of pediatric specialists, 84% of pediatricians, 84% of audiologists and 73% of respiratory therapists are located in four counties of the state. About 48% of the State's child population lives in these four counties but only 38% of the children served through he state CSHS program live in these four counties. According to survey results, families reported traveling more than 100 miles one way to visit their child's pediatric specialist. 13.6% of survey respondents said they had gone out of state to access care for their child with special health care needs.

The Maternal and Child Health Division provides health education services in a variety of ways: by providing continuing education to state and local agency staff, providing technical assistance

and consultation to providers and the public, and providing a variety of health education materials. This same function is also carried out at the community level by local public health departments.

The CSHS Division provides support to families of children with special health care needs through partial financial support of a statewide family to family support network. The number of families receiving support and information through the network has grown over the past year.

The degree to which children with special health care needs and their families have access to coordinated care was assessed. Only 25.7% of CSHCN surveyed indicated they had a case manager and only 14.6% said they had a written plan of care for all of their child and family's needs. The ND Medicaid Program continues to implement a Medicaid Primary Care Physician Program (PCP) and a Targeted Case Management Program for Pregnant Women. Children with mental retardation are served through Developmental Disabilities Case Management program and children with mental health disorders are served through a regional program of care coordination. The Medicaid Division has considered applying for a waiver to enhance Medicaid reimbursement for preventive services provided to children with mental health disorders. Care coordination for children with special health care needs is provided through all county social service offices and two local public health departments. Preliminary meetings have held with the Medicaid Division regarding Medicaid reimbursement for care coordination.

Although the WIC Program is not funded by Title V, it is a significant part of the MCH Division. Having the WIC Program within the MCH Division is an asset for other programs and leads to greater communication and collaboration between programs affecting the health of pregnant women, infants and young children. The unduplicated counts for FY '98 in the ND WIC Program are as follows:

Pregnant, Breast feeding and Delivered Women	7,444
Infants	7,396
Children	12,175
Total WIC Clients	27,015

3.1.2.4 Population-Based Services

Local public health departments, partially funded with MCH funds, provide population-based services for the MCH population in their community. Some of these services include immunizations, home visiting, pre-school screening, infant and child assessment, nutrition, oral health, injury prevention, contagious disease control, and school health.

The MCH Division continues to direct the Newborn Screening program. All newborns are receiving metabolic screening through the Iowa Neonatal Newborn Hearing Screening Program.

Local public health departments provide lead screening through the ND Health Tracks (EPSDT) Program. The MCH Division has developed standards of care for this procedure and maintains a computer record of the number of children screened and the number of childhood lead poisoning cases.

North Dakota Century Code authorizes follow-up of Sudden Infant Death Syndrome (SIDS) events. Along with a letter and information being mailed to parents, cases are referred to local public health nurses and family support groups for interventions. The MCH Division works closely with the state medical examiner in these cases. The Child Fatality Review Panel also reviews all deaths reported as SIDS.

Ensuring immunization compliance is a cooperative effort between several programs in the DoH, local health departments and private providers. The Vaccine for Children Program and the Prevention Partnership Program help insure children are immunized.

MCH staff in oral health, injury prevention and nutrition assists local agencies in providing population-based services in their specialties. These activities are incorporated into programs conducted at the state level such as school health, child health nursing conferences, and prenatal classes.

Collaborative efforts exist between public health and the Medicaid program. Local agencies are Medicaid providers for the primary preventive services they provide. As Medicaid providers, local public health departments informally provide outreach services for the Medicaid program by referring potentially eligible recipients for coverage. In addition, staff from Medicaid frequently meet with local health department staff at their quarterly meetings.

The most significant population-based service for the CSHCN population continues to be outreach and public education. Collaborative outreach efforts and passive birth defect surveillance continues with the Birth Review program and other ChildFIND related activities. Families with newborns are sent educational materials and other information in order to identify infants at risk for developmental delays.

3.1.2.5 Infrastructure Building Services

The mission of the Maternal and Child Health Division results in the development of standards, policies, procedures and budgets and the provision of leadership, direction, training and technical assistance to local public health agencies and other non-profit entities to help ensure the health and safety of the maternal and child population.

Infrastructure within the MCH Division is based on collaborative efforts between the state and local agencies. Staff with expertise in various areas such as nutrition, nursing, injury prevention and oral health provide continuing education, consultation, funding and other resources to local agencies. These local agencies in turn carry out the grass roots core public health functions. This infrastructure ensures a trained work force to carry out the public health responsibilities of primary preventive services across the state.

Staff within MCH programs set standard of care for local agencies by developing policies and procedures, often through program manuals. Local agencies receiving MCH funds are required to complete community needs assessment, develop plans and implement these plans based on standards

of care. Reporting on progress of their objectives and how MCH funds are being used allows for the evaluation of the effectiveness of programs and accountability for funds.

Local public health departments were provided with mandated and state negotiated performance measures when they received their requests for proposal. This gave them guidance in objectives MCH Division would be addressing during FY '01. Many local agencies may see the same needs within their communities and develop activities to address like issues.

Involvement in Core Public Health Training and the Minnesota Department of Health grant entitled "Public Health Nursing for the 21st Century: Competency Development in Population-Based Practice" are two additional examples of MCH Division involvement in public health policy and development of standards. MCH staff in other disciplines provide the same type of infrastructure enhancements.

Information related to infrastructure is located in other sections of this grant application. The entire portion of the grant application **"State Agency Capacity" 1.5.1** contributes to the infrastructure of the Maternal and Child Health Division. The staff, programs and collaborative efforts are all part of the overall infrastructure.

Another example of the extent of the MCH staff ability has been the recognition by their peers nationally. Staff in oral health, nutrition and the WIC Program have all served as leaders in their national organizations. This is an indication of the quality of MCH staff.

The MCH Advisory Committee was established in December 1996. The purpose of the committee is to promote the health for the ND MCH population, to advise the division on health issues, and advocate for women and children health issues. They do not have policy enforcing powers.

In follow-up to a videoconference held in 1998 entitled *Measuring Up: A Blueprint for Success*, a set of quality assurance indictors for the maternal and child health population was developed. The SSDI Project Coordinator enhanced infrastructure development activities through development of an ongoing system of data collection and analysis.

CSHS staff utilizes Medical and Family Advisory Council recommendations and meet regularly to develop policy related to the children with special health care needs. The State Children with Special Health Care Needs program assures quality through provider standards and credentials for participating physicians and other health care providers, the development and promotion of standards of care in the community care coordination programs, through contracted services, quality improvement reviews, and site visits.

The Children's Services Coordinating Committee (CSCC) is an example of a statewide infrastructure designed to address the needs of children at risk. Over the past three years, the SSDI program has concentrated efforts at providing financial and technical assistance to Regional and Tribal CSCCs to improve their ability to address the health and related needs of children at a community level. A state negotiated performance measure was developed to assess the percentage of CSCC funds that were being devoted to health related issues. The percentage increased from 27% in 1997 to 39% in 1998 and to 57% in 1999.

A state level infrastructure for the maternal and child health population is enhanced through Title V staff participation in a number of collaborative activities. CSHS staff has membership on the Interagency Coordinating Council, a Fetal Alcohol Syndrome Task Force, and March of Dimes and Emergency Medical Services for Children groups. CSHS staff has also facilitated formal working relationships with the Social Security Administration around SSI for children and the State Vocational Rehabilitation agency. Special emphasis has taken place around collaborative childhood to adult transition planning for children with special health care needs.

Emphasis on the need for coordinated care and services for children with special health care needs and their families had led to increased collaboration with other agencies providing care

coordination or targeted case management services for selected populations. Working relationships have been enhanced with Medicaid and the developmental disabilities case management system.

CSHS maintains linkages with the private health care system through its Medical Advisory Council. The CSHS Medical Director is a practicing pediatrician and an active member of the state chapter for the American Academy of pediatrics.

CSHS assures standards of care for children with special health care needs through a variety of activities. CSHS maintain a medical provider list in which only properly licensed certified physicians can be approved for payment of services to eligible CSHCN. For the first time, CSHS planned and administered a training session for CSHS county social service staff in October 1999. The training emphasized outreach, information and referral services at the local level and future enhancements to the care coordination role of county staff. CSHS has recently updated the policy and procedure manual and this will be shared with county social service in the near future. CSHS continues to promote Bright Futures as the model standard of well-childcare for all children.

3.2 Health Status Indicators

North Dakota was able to collect data and report on all but one core health status indicator and most of the developmental indicators. For Core HSI 02B, there were no one year olds in the State CHIP program for any of the reporting years 1995-98. Phase One of the State CHIP plan began in 1998 and was a Medicaid expansion for 18-year-olds. Phase Two was a more comprehensive plan for all children but only began in October 1999.

For Core HSI 05, ranking the state's data capacity, ND rated better in the registries and surveys category than annual data linkages. Technical assistance from CDC is planned for this summer to help the state assess data capacity and develop an improvement plan. Development of an integrated MCH data system has begun and initial explorations of the feasibility of a birth defects registry are underway. Improvements in the state's data capacity will be addressed through SSDI program goals and objectives.

North Dakota was not able to collect data for Developmental HSI 02A, the rate per 100,000 of all nonfatal injuries of children 14 years old and younger. There is no reliable data source for this indicator and E-coding is inconsistent in the State's claims system. We were not able to find reliable estimates for childhood poverty for Developmental HSI 11 and 12 other than dated 1990 Census data.

3.2.1 Priority Needs

Twenty-six initial priority needs were established for the maternal and child health population. This represented 4-6 priorities for each of the 5 population groups identified. The priority needs identified for each population group were:

Women (of childbearing age):

- Healthy weight and nutritional status
- The need for pre-pregnancy vitamin intake
- Domestic violence
- The early initiation of prenatal care
- Unplanned or unintended pregnancies
- The need for pre-conception counseling

Infants (age birth to 1):

- Promotion of the importance of breast feeding
- The effects of prenatal and maternal smoking on infant health
- Behaviors associated with SIDS deaths
- Infant mortality rates

Children (age 1 through 10):

- Immunization rates

- Access to health care and other services
- Child abuse and neglect
- The number and causes of child deaths
- Overweight and the lack of physical activity
- The causes of pediatric hospitalization

Children with Special Health Care Needs (age birth to 21):

- The impact of chronic health conditions and congenital anomalies on children and their families
- The degree of coordinated care
- Financial access to specialty care and related services
- The availability of specialty care and related service providers

Adolescents (age 11 through 21):

- Tobacco and alcohol usage
- The number of deaths due to suicide
- Eating disorders and nutritional behavior
- The number of deaths due to motor vehicle crashes
- The rate of sexually transmitted diseases
- Racial disparities in the teen birth rate

The priorities were ranked as to level of importance within each population group. Each priority was reviewed to determine if the needs could be addressed though activities related to an existing federal performance measure, MCH and CSHS collaboration with other DoH programs (i.e., health promotion and education, disease control) or other State agencies, or through separate interventions requiring a state negotiated performance measure.

It was determined that a few of the identified priority needs can best be addressed through collaborative activities with other State agencies and public and private organizations. Many of priorities will be addressed through workplan activities around existing federal performance measures. Following are the ten state priorities that were not addressed through existing federal measures and required state negotiated measures, organized by the four levels of the pyramid.

Direct Health Care Services:

1. For children to receive necessary health care services in school.

Enabling Services:

2. To increase the percentage of Medicaid eligible children who receive dental services.

Population Based Services:

3. To reduce the rate of abuse and neglect in infants and children.
4. To increase the percent of young adults who are of normal weight.
5. To increase the number of pregnancies that are intended.
6. The effects of prenatal and maternal smoking on infant health.
7. For women of childbearing age to use folic acid.
8. To reduce the number of deaths due to unintentional injuries to children and adolescents.

Infrastructure Building Services:

9. To reduce the impact of congenital anomalies and chronic health conditions on children and their families.
10. For children with special health care needs to receive necessary specialty care and related services.

3.3 Annual Budget and Budget Justification

The MCH Division Budget for 2001 Form #3 includes: $1,319,955.00 federal funds based on Year 2000 grant award plus state funds of $764,020.00 and local funds of $231,736.00 for a total MCH budget of $2,315,711.00. Form #4 depicting population group funding is self-explanatory. The category "Other" is Title V funds supplementing the Family Planning Program.

Proposed budget for MCH Division Form #5 includes: $92,000.00 under Direct Health Care Services which is Title V funds allocated for the Family Planning Program; $1,231,834.00 under Population Based Services depicting local health services with federal and non-federal match funds; and $991,877.00 under Infrastructure Building Services. This reflects primarily state level activities and indirect cost. Total is $2,315,711.00.

Proposed budget for the CSHS Division includes: $814,048.00 for direct health care services, $385,528.00 for enabling services, $96,501.00 for population-based services, and $903,849.00 for infrastructure-building services. These estimates are based on 1999 expenditures and include $65,998.00 in CSHS administration. Total CSHS budget is $2,199,926.00.

3.3.1 Completion of Budget Forms

Budget Forms # 3, #4 and #5 completed for 2001.

3.3.2 Other Requirements

In accordance with Section 505, the ND Title V Program will use funds allocated under this title to assess the need for preventive and primary care services for pregnant women, mothers, infants and children, including those with special health care needs. A plan for use of Title V funds for the provision and coordination of services to carry out the MCH Program will be submitted. The budget will allocate $593,980.00 (30%) to Component B and $659,978.00 (33.33%) plus $65,998.00 administrative costs to Component C. The total amount allocated for Component C is $725,976.00 or 33% of total federal allotment. Administrative costs will not exceed 10% of the allocation. The state will meet maintenance of effort requirements as established in 1989.

Special consideration will be given to pre-1981 projects. The First District Health Unit in Minot was the recipient of special pre-1981 funding for the program titled "The Program of Projects." The First District Health Unit has a FY '00 contract for funds to carry out these projects.

Title V funds are allocated to a variety of local preventive health service providers who serve families through local public health departments, Indian Reservations, etc. The majority of these agencies match federal dollars received with state or local funds.

Title V assures that no charge will be made to "low-income" families. All agencies receiving funds must assure the state MCH office that if any charges are imposed for the provision of health services, such charges will not be imposed on services to low-income families and will be adjusted to reflect the income, resources, and family size of the individual. No ND Title V Program will refuse services to anyone because of inability to pay. Some agencies may accept donations for services. Other funds administered by the MCH Division include the Family Planning Program, Abstinence-Only Education, SSDI, Domestic Violence Prevention and STOP Violence Against Women, Consumer Product Safety Commission, and WIC.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3

TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

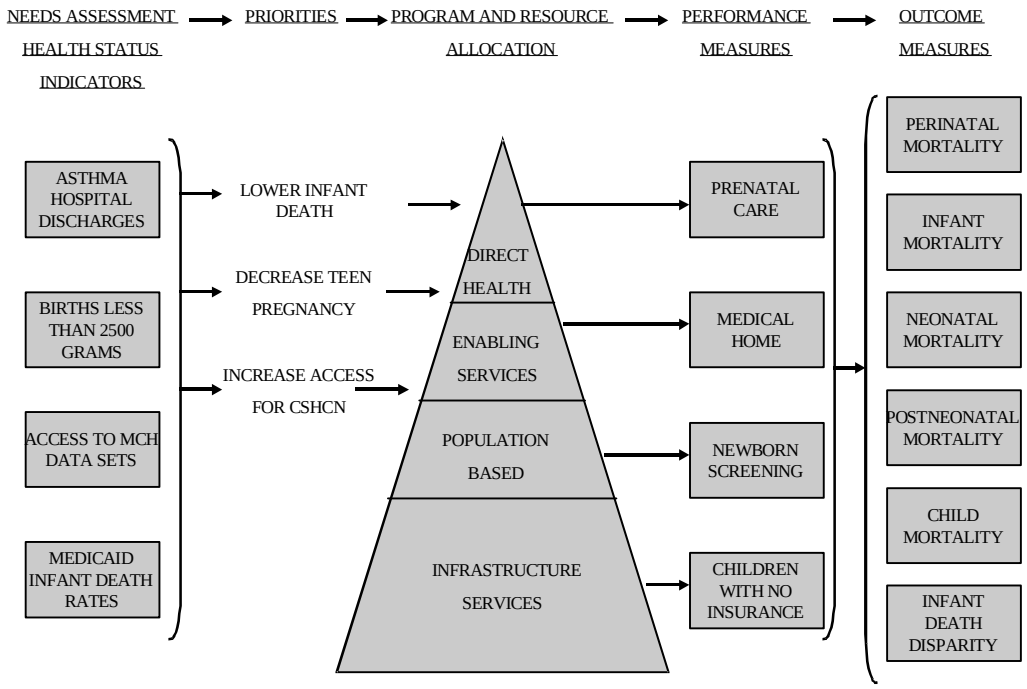


Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers whom breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
3) The rate (per 1,000) of abuse and neglect in infants and children from birth to age 5.			X				X
4) Increase the percent of normal weight among young adults 18-24 years of age.			X				X
5) Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.		X				X	
6) Ratio of school nurses to students in ND.	X				X		
8) The proportion of pregnancies that are intended.			X				X
9) Percent of women who use tobacco during pregnancy			X				X
10) Rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17.				X		X	
11) The percent of CSHCN served by CSHS with a specialty care visit.				X	X		
12) The percent of women who use a multivitamin supplement prior to pregnancy.			X				X
13) The rate of deaths to children aged 1-19 caused by unintentional injuries per 100,000 children.			X				X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.4.1.1 Five Year Performance Objectives

Five-year performance objectives for all national core performance measures and state negotiated performance measures are listed on Form 11.

3.4.2 State "Negotiated" Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

Detail sheets for state negotiated measures are included in Supporting Documents 5.10.

3.4.2.2 Discussion of State Performance Measures

For children to receive necessary health care services in school. This priority was chosen because ND has no coordinated, statewide school health program. Not all schools have access to school nursing services and most of those that do only have access to a nurse part-time. Most school nurses are from local public health departments and not employed by school districts. The State Title V program needs to support efforts to increase school nursing so children have access to necessary health care in school. The state negotiated performance measure selected for this priority need was the ratio of school nurses to students in ND. This is a direct health care service and may impact Outcome Measure # 6 - The child death rate per 100,000 children aged 1-14.

To reduce the rate of abuse and neglect in infants and children. Because of different reporting definitions, it was difficult to determine accurate trend data or national comparisons. This priority need was chosen because there are a number of primary and early intervention activities coordinated by maternal and child health and other private and public agencies which can be expected to reduce abuse and neglect and improve health outcome for infants and young children. The state negotiated performance measure selected for this priority is the rate of abuse and neglect in infant and children from birth to age 5. This is a population-based service and may impact Outcome Measure # 6 - The child death rate per 100,000 children aged 1-14.

To increase the percentage of Medicaid eligible children who receive dental services. This priority was chosen because there are a number of barriers to health care for children. Access to necessary health care can be assessed in many ways. Medicaid eligible children who receive dental services are one way in which access to health care can be measured. The state negotiated performance measure selected for this priority was the percent of Medicaid eligible children who receive dental services as a part of their comprehensive services. This is an enabling service and may be related to several outcome measures.

To increase the percent of young adults who are of normal weight. This priority need was chosen because according to trend data reviewed, there are increased concerns for the weight, activity levels and nutritional behavior of young children, adolescents and young adults. The state negotiated performance measure selected for this priority needs was the percent of normal weight among young adults 18-24 years of age. This is population-based service and may impact several outcome measures, as healthy maternal weight is associated with healthy birth outcomes.

To increase the number of pregnancies that are intended. This priority was chosen because according to data reviewed, the percent of pregnancies that are intended in ND is below Healthy People 2010 targets. There are also substantial racial disparities between the White and Native American population. The state negotiated measure selected for this priority need is to increase the proportion of pregnancies that are intended. This is a population-based service and may be related to several birth outcome measures.

The effects of prenatal and maternal smoking on infant health. This priority was chosen because prenatal and maternal smoking contributes to adverse health outcomes for mothers, infants and children. Birth certificate data show an increase in the percentage of women who smoked during their pregnancy over the past three years. The state negotiated performance measure chosen for this priority was to reduce the percent of women who use tobacco during pregnancy. This is a population-based service and may impact several outcome measures as prenatal maternal risk behaviors are related to healthy birth outcomes.

To reduce the impact of chronic health conditions and congenital anomalies on children with special health care needs and their families. The specific priority need was for children with special health care needs to receive necessary medical management. This priority need was selected because according to CSHS Family Survey data, chronic health conditions impact children and families in a number of ways. Proper medical management for children with chronic conditions can reduce pediatric hospitalizations and improve the child's quality of life in other ways. Asthma was chosen as the chronic condition to be measured because 10% of CSHS Family Survey respondents listed a diagnosis of asthma/respiratory, ND health care claims data show an increased rate of hospitalization with a principle diagnosis of asthma, and research indicates an increase in prevalence nationally. The state negotiated performance measure selected for this priority need was the rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17. This is an infrastructure building service and may impact Outcome Measure # 6 - The child death rate per 100,000 children aged 1-14.

For women of childbearing age to use folic acid. The rate of births with neural tube defects has remained constant and according to survey data, more women are taking folic acid-containing vitamin supplements during pregnancy. However, increased knowledge and information about the benefits of folic acid in the prevention of neural tube defects and other birth defects continues to be important. The state negotiated performance measure selected for this

priority was the percent of reproductive age women who use multivitamin or folic-acid-containing supplements. This is a population-based service and may impact several outcome measures.

To reduce the number of deaths due to unintentional injuries to children and adolescents. This priority was chosen because deaths due to unintentional injuries continue to be the leading cause of death to children and adolescents in the State. For some age groups, death rates for ND children exceed national rates. The state negotiated performance measure chosen for this priority need was the rate of deaths to children aged 1-19 caused by unintentional injuries per 100,000 children. This is a population-based service and impacts Outcome Measure # 6 - The child death rate per 100,000 children aged 1-14.

For children with special health care needs to receive necessary specialty care and related services. This priority was chosen because CSHS Family Survey data indicate children with special health care needs are not receiving specialty care and other services as often as necessary. There are small numbers of pediatric providers in the state overall and the geographic location of medical providers and travel distance for families creates barriers to receiving necessary services. The state negotiated performance measure selected for this priority was the percent of CSHCN served by CSHS with a specialty care visit. This is an infrastructure building service and may be related to Outcome Measure # 6 because the degree to which CSHCN receive specialty care services could impact child mortality.

3.4.2.3 Five Year Performance Objectives

Five-year performance objectives for each negotiated state measure are included on Form 11.

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

Detail sheets for each federal outcome measure and one additional state negotiated outcome measure are in included in Supporting Documents 5.11.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

4.1 Program Activities Related to Performance Measures

See following tables.

NORTH DAKOTA – 2001

Type: C **Category: DHC** **X Federal State**	**Performance Measure #1:** The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	9	**9**	**9**	**9**	**9**

Narrative: A five-year goal for the CSHS Division is to ensure that rehabilitative services are provided for SSI beneficiaries to the extent Medicaid does not provide them. Since 9% of SSI beneficiaries received rehabilitative services from CSHS in fiscal year 1998 and 1999, the performance target for this measure was increased from 7% to 9% for the 2001 fiscal year.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, CSHS will identify children with special health care needs receiving SSI and link their families to services.	Continue to work with IMD staff to refine SDX-generated reports so they can be easily utilized for SSI outreach as well as monitoring purposes.	The annual SSI report generated from the SDX system will be revised.
	Draft a memorandum of understanding between Disability Determination Services (DDS) and CSHS to facilitate automatic referral of SSI-eligible children and SSI cessation's from DDS to CSHS.	By 9/30/01, CSHS and DDS will have a signed memorandum of understanding.
	Develop an outreach mailing for families targeting SSI beneficiaries who are not receiving Medicaid.	An outreach mailing will be conducted by 9/30/01.

During FY '01, CSHS will continue to promote the SSI program to families.	SSI information will be distributed through various CSHS public information activities including display opportunities and information request cards.	The Public Information Service report and SSI report will contain distribution data on SSI materials.

Type: C **Category: DHC** **X Federal State**	**Performance Measure #2:** The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)

Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	8	**8**	**8**	**8**	**8**

Narrative: The five-year goal for this measure is to maintain the current degree of support for specialty services. Historically, eight out of the nine listed services have been provided or paid for by CSHS. If possible, access to care coordination services will be increased.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Increase access to diagnostic and treatment services for CSHCNs during FY '01.	Evaluate impact of financial eligibility change to 185% of poverty without assets that was made in FY '00.	Program data on the number of CSHCNs served and CSHS financial reports will be available.
	Explore expansion of CSHS eligible medical conditions and scope of covered services.	CSHS Medical Advisory Council meeting minutes will reflect medical eligibility and scope of covered services on the agenda. CSHS policy and procedure manual will be revised to include additional covered conditions and services, if financially feasible.
	Maintain an up-to-date provider list of ND specialists that meet CSHS qualification requirements.	A provider list will be available in CSHS and disseminated annually to county social service staff.
	Coordinate benefits for specialty services provided or paid for by CSHS.	CSHS authorizations processed efficiently.

During FY '01, provide information, technical assistance and training to county social service staff who work with CSHS programs.	Provide a CSHCN newsletter to county social service staff. Provide ongoing technical assistance about Specialty Care Program eligibility to county social service staff. Facilitate annual training for county social service staff.	At least one newsletter will be disseminated during FY '01. Log of contacts maintained in client files at state office. Annual training event will be held.
During FY '01, increase the percentage of children served by CSHS who receive care coordination services.	Provide technical assistance to county social service staff providing comprehensive care coordination services for children that receive treatment services through CSHS. Provide care coordination to families through the Public Health Care Coordination Programs and expand sites if possible. Facilitate care coordination training for public health nursing and county social service staff.	Log of contacts maintained in client files at state office. Availability and quality of comprehensive, written service plans for children receiving care coordination monitored and reported. Service contracts for care coordination available. Care Coordination quarterly and annual reports disseminated. Training opportunity provided.
During FY '01, CSHS will provide public information services to improve access to care.	A CSHS workgroup will develop and implement a public information plan during the fiscal year.	A Public Information Services report will be available to document accomplishment of planned activities.

Type: C **Category: ES** **X Federal State**	**Performance Measure #3:** The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home." **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)				
Projected PM:	**FY' 01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	92.0	**92.1**	**92.2**	**92.3**	**92.4**

Narrative: The five year goal for this measure is to incrementally increase the number of CSHCNs in the state who have a medical/health care home. It would be idealistic to expect a large increase when the percent is already so high.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, determine the number of children served through the CSHS Care Coordination Program who have a medical home.	Develop a working definition of medical home and conduct a chart review.	Data on the number of children with a medical home will be available for children receiving care coordination services through CSHS.
During FY '01, promote the concept of the medical home with providers, county social staff and families.	Participate in CompCare TA activities. Obtain the medical home training curriculum from the AAP and adapt content for use with county social service staff. Provide public information services to improve access to and appropriate use of a medical home by CSHCNs and their families.	A social marketing plan and implementation strategies (including identification of resources) to increase understanding by families of the importance of preventive services and to promote the utilization of preventive services will be available. Medical home training for county social service staff will be provided at annual training event. The CSHS Public Information Workgroup will disseminate information on the medical home concept in addition to Bright Futures Health Supervision Guidelines as part of the Division's overall public information services plan.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #4:** Percent of newborns in the state with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (combined). **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	100	**100**	**100**	**100**	**100**

Narrative: The new web-based computer system developed by the Iowa Neonatal Metabolic Screening Program has improved the tracking and follow-up of infants screened leading to more efficiency in follow-up and reporting.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Evaluate and if needed expand newborn screening outreach/ education efforts.	Using information from 2000 review of data from newborn screening/vital records match implement at least one activity to reach the health care providers or parents of infants that are at high risk of missing a newborn screen.	One activity will be conducted by September 30, 2001

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 5:** Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Hemophilus Influenza, Hepatitis B. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	84	**84.2**	**84.4**	**84.6**	**84.8**

Narrative: The Immunization Program in the DoH is located in the Disease Control (DC) Division. MCH works closely with this division and local agencies to promote immunizations of infants and children.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Work with the DC Division to improve the percent of children receiving their basis immunizations.	Collaborate with the MCH Forms/Manual Committee and the DC Division to initiate process in developing standards for	Dialogue initiated by June 30, 2001.

	immunizations by updating the Immunization Section of the MCH Manual. Provide funding to local health departments for use in administration of immunizations in their communities. Collaborate with childcare agencies in promoting health and safety in the childcare setting, including immunization.	 Of the 26 local health departments, at least 15 will indicate MCH funds are used for immunization administration. MCH staff will participate and record all activities related to childcare and promotion of immunizations.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #6:** The birth rate (per 1,000) for teenagers aged 15 to 17 years. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	16.7	**16.6**	**16.7**	**16.8**	**16.9**

Narrative: North Dakota has a small overall population with the number of children and adolescents on the decline. The state also has a relatively small percentage of births to teenagers. Thus, activities conducted by the MCH Division may not have a major impact in reducing the number of teenage births. Also, because of the relatively small numbers, even small increases or decreases will create rapid highs in lows in these statistics.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Reduce or maintain rate of teenage pregnancies.	The ND Title V MCH Division will apply for Abstinence-Only Education Grant funds. The MCH Division will continue to monitor the incidence of ND teenage births.	Funds applied for and grant awarded. Vital Records Division data will be used to monitor incidence of teenage pregnancies.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #7:** Percent of third grade children who have received protective sealants on at least one permanent molar tooth. **Healthy People 2010 Objective:** Objective 21-8				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	54	**54**	**55**	**55**	**55**

Narrative: The five-year goal is to maintain our high rate of sealant prevalence among third graders and slightly increase the rate if possible. With access to care a major challenge for low-income families and the provider shortage issue in the state, incrementally increasing sealant prevalence will be a major challenge.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
By September 30, 2001, widely distribute results of the 2000 ND Oral Health Survey of Third Graders.	Prepare summary report of survey findings. Distribute summary findings to local health agencies, dental providers, policy makers, and the media. Post-summary findings on the DoH web site.	Summary report of dental survey published. Summary findings of dental survey distributed to key stakeholders. Summary report of dental survey posted on web site.
During FY '01, continue distribution of information on dental sealants.	Provide information on dental sealants in school health education programs.	Number of schools and number of children receiving sealant education.
During FY '01, promote use of dental sealants to dental providers.	Provide latest research and information on dental sealants to dental providers in the state.	Current information/research on dental sealants provided to dentists.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure #8:** The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
(3-yr. running average)	**4.3**	**4.2**	**4.1**	**4.0**	**3.9**

Narrative: Motor vehicle crashes are the leading cause of unintentional injury death for ND children aged 1-14. Child restraint use has increased for younger children, but observation surveys found only 60% of children aged 6-10 in a seat belt. Efforts will continue to maintain high car seat use for infants and children, but priority will be placed on increasing restraint use by older children.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Increase proper use of car safety sea and seat belts by children.	Coordinate activities to increase proper use of safety seats, including public information, education, distribution of car safety seats, car safety checkups, and training.	Increased use of car safety seats and seat belts, as measured by observation surveys done biennially.
	Coordinate a buckle up campaign during February's Child Passenger Safety Awareness Week.	Campaign completed. Number of agencies participating.
Continue car seat distribution program.	Prepare grant applications to Department of Transportation. Purchase and distribute car seats to local sites. Provide appropriate forms, videos and training to local coordinators.	Number of car seats distributed.
Provide training on child passenger safety.	Two NHTSA 4-day standardized child passenger safety courses will be conducted. A four-hour training will be provided to new law enforcement officers as part of their basic training. Two 2-day	Training sessions completed. Number of participants.

	Child Passenger Safety workshops will be conducted.	
Conduct presentations to 100-150 junior/senior high school classes on seat belt safety.	"Think First" presentations will be done by ND Nurses Association. The father of a child who died in a car crash will also do presentations.	Number of presentations, number of participants, pre-tests and evaluations.
Increase use of bike helmets by children.	Provide bike helmets, educational materials, technical assistance and incentives to local agencies to encourage use of helmets. Monitor and/or support legislation to require helmet use.	Number of helmets and materials distributed. Increase the number of children who wear bike helmets 75-100% of time as reported by parent on post-helmet distribution surveys.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 9:** Percentage of mothers whom breastfeed their infants at hospital discharge. **Healthy People 2010 Objective:**

Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
(3-yr. running average)	**62**	**64**	**66**	**67**	**69**

Narrative: The breast feeding rate for ND has steadily (but very slowly) increased over the past twenty years. The projections are a continuation of this trend. MCH activities are closely coordinated with the breast feeding promotion and support activities of the ND WIC Program.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Begin planning annual breast feeding conference for calendar year 2002.	Identify lead persons in Grand Forks, to pull together a conference-planning group by November 2000. Reserve location for conference by February 2001. Begin regular meeting of group by June 2001.	Group formed and meeting on regular bases. Location reserved.
Place statewide breast feeding statistics on the ND Health	Discuss type of data needed with local agencies.	Data place on Website by September 30, 2001.

Department Website.	Identify a user-friendly format for data.	
Promote recognition of those who attend the Fargo, ND workshop sponsored by ND WIC and the Center for Breast feeding Lactation Consultant Training.	Provide information to various local agencies about the conference and help arrange for media recognition of attendees.	Conference will be held November 2000. News releases or other coverage of conference will be coordinated with ND WIC program.
Identify strategies that will help support the breast feeding mom that returns to the workforce.	Review with local public health staff, the needs they see in community and identify strategies to help support mothers.	A list of strategies will be developed by September 2001
Disseminate information on extent of WIC services that are available to promote breast feeding.	Identify at least two strategies for increasing the knowledge of the public and/or breast feeding about WIC breast feeding support activities. Implement at least one strategy.	Implement and evaluate effectiveness strategy to increase knowledge of WIC breast feeding support activities.

Type: RF **Category: PBS** **X Federal State**	**Performance Measure # 10:** Percentage of newborns who have been screened for hearing impairment before hospital discharge. **Healthy People 2010 Objective:** 17.6 and 17.16 (2010 Objective: 28-11)

Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	45	**75**	**86**	**90**	**90**

Narrative: CSHS partnered with the ND Center for Persons with Disabilities (NDCPD) in developing an application for a Universal Newborn Hearing Screening (UNHS) grant. The grant was awarded 3/2000. With the grant funding, a UNHS program will be implemented over a four-year period. The grant will first target birthing hospitals with the highest number of births in an effort to reach the largest number of children.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, CSHS will promote universal newborn hearing screening.	A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the UNHS Program. CSHS will administer an annual newborn hearing screening survey to all birthing	Progress will be made on the UNHS grant objectives. Survey results available.

	hospitals in the state. A CSHS staff member will serve as the Title V state hearing contact.	 Information regarding hearing screening will be disseminated to interested stakeholders.

Type: C **Category: IB** **X Federal State**	**Performance Measure #11:** Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care. **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	87.0	**87.1**	**87.2**	**87.3**	**87.4**

Narrative: Targets for this performance measure are relatively flat because significant increases in the percent of CSHCNs served by CSHS with a source of insurance are not expected unless the CHIP Program in ND serves families with incomes above 140% of the federal poverty level.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, monitor the number of CSHCNs served by CSHS with a source of health care coverage.	CSHS staff will collect, compile, analyze and summarize data on insurance status for CSHCNs served by CSHS.	Annual health care coverage report will be available.
During FY '01, conduct activities to refer and link families that have CSHCNs to available sources of health care coverage.	Uninsured CSHCNs served by CSHS will be identified and outreach mailings sent regarding Medicaid, CHIP and Caring programs. State and local staff will support families in completing applications when needed.	The percent of CSHCNs with a source of insurance will increase.

Type: C **Category: IB** **X Federal State**	**Performance Measure #12:** Percent of children without health insurance. **Healthy People 2010 Objective:**				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	16.3	**16.2**	**16.1**	**16.0**	**16.0**

Narrative: At present, we have no reliable data source to report the percent of children in the state who are uninsured. The reported percent of uninsured children in the state is based on a 1998 statewide survey conducted by the Robert Wood Johnson Family Foundation. Other estimates from the State Data Center estimate the percentage to be higher than survey results.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, Title V staff will collaborate with statewide outreach and enrollment strategies for children's health insurance.	Participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids" grant.	CHIP enrollment meets or exceeds projected levels
During FY '01, Title V will identify reliable data sources to accurately estimate the percent of uninsured children in the state.	Evaluate existing state and national estimates. Select optimal source for reporting.	Accurate levels reported in FY '02 Grant Application

Type: P **Category: IB** **X Federal State**	**Performance Measure #13:** Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	97	**97**	**97**	**97**	**97**

Narrative: Through collaboration with the state Medicaid program and participation in CHIP outreach and enrollment activities, the 5-year goal of the Title V program is to increase the number of children in the state with a source of health insurance coverage.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, Title V will continue	MCH and CSHS staff will continue to meet	Attendance at scheduled meetings

to collaborate with the ND Health Tracks (EPSDT) and Healthy Steps (CHIP) administered by the state Medicaid program.	regularly with Medicaid and ND Health Tracks staff MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid outreach, enrollment, and application procedures.	Information provided as needed

Type: P **Category: IB** **X Federal State**	**Performance Measure #14:** The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	12	**12**	**12**	**12**	**12**

Narrative: CSHS seeks participation from families in the development of policy and programs. This is primarily carried out through a Family Advisory Council to the CSHS Division. We expect there to be variations in the ratings for each of the six characteristics from year to year**.**

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Through 9/30/01, CSHS will continue to include family advice and recommendations when making program and policy decisions	Financial support and reimbursement will be offered to Family Advisory Council members to support participation. Explore feasibility of family input through contract or paid staff position.	Consultant fee, mileage, meals and lodging reimbursement will have been paid to Family Advisory Council members. Discussions will have been held during biennial budget preparation and planning.
During FY '01, CSHS Family Advisory Council members will assist in the planning of training for CSHS county social service staff.	Training agenda and content will be reviewed with Family Advisory Council members.	Advisory Council review will be reflected in meeting minutes. Advisory Council accountability will be assessed through Recommendation/Review Form. County training session held.
By 9/30/01, family members will assist CSHS in planning focus	Family Advisory Council members and State Family Voices Coordinator will assist	At least one community focus group will be held

groups to enhance community needs assessment for CSHCNs.	in the planning and facilitation of parent focus groups.	
During FY '01, CSHS will support a Family-to-Family network	Provide partial funding to support network activities. Assist in network maintenance and expansion.	A contract will be available and funding provided. The support network will continue to function in ND. CSHS staff will serve on the Family-to-Family advisory board.

Type: RF **Category: IB** **X Federal State**	**Performance Measure #15:** Percent of very low birth weight live births. **Healthy People 2010 Objective**:

Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	1	**1**	**1**	**1**	**1**

Narrative: MCH will monitor this performance measure. Prematurity is the leading cause of infant death. There are many risk factors identified for low birth weight such as younger and older maternal age, late prenatal care, smoking, substance abuse, sexually transmitted infections, etc.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Continue to participate in the FAS inter-agency task force.	MCH staff to participate in the activities of the FAS task force and to encourage primary prevention activities by the task force.	Attendance at meetings.
Provide nutrition education to pregnant mothers.	OPOP programs will provide nutrition education for OPOP clients. WIC to provide nutrition education to women receiving WIC services.	Nutrition education continued in both OPOP and WIC Programs.
Provide supplemental nursing, social services and nutritional education/services to high-risk pregnant women through the Optimal Pregnancy Outcome Program (OPOP).	Provide partial funding of OPOP activities. Coordinate Statewide meetings of OPOP coordinators and staff. Gather data on birth outcomes and	OPOP programs continue to provide services. Meetings held as scheduled. Statewide data reports sent to each OPOP

	associated risks. State wide data report distributed to OPOP Coordinators. Complete section VII (Education/Referral/Counseling) of the OPOP manual.	Coordinator. Section VII of the OPOP manual finalized.

Type: RF **Category: IB** **X Federal State**	**Performance Measure #16:** The rate (per 100,000) of suicide deaths among youths ages 15-19. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
(3-yr. running average)	**19.5**	**19.0**	**18.5**	**18.0**	**17.5**

Narrative: North Dakota's adolescent suicide rate is higher than the national average. The Injury Prevention Program established a statewide Suicide Prevention Task Force and assisted with development of a State Plan for Adolescent Suicide Prevention. The plan describes the problem of youth suicide in ND and the nation, discusses characteristics of youth at-risk for suicide, outlines the recommendations of the US Surgeon General, and provides recommendations specific to ND.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Continue program involvement in adolescent suicide prevention.	Finalize draft of State Plan for Adolescent Suicide Prevention, print, and distribute. Coordinate activities of the State Adolescent Suicide Prevention Task Force. Serve on State Oversight Committee for CSCC grant to ND Mental Health Association Begin implementation of State Plan recommendations.	Plan completed, number distributed. Two to three meetings held. Grant objectives carried out. At least two recommendations will be completed.

Type: RF **Category: IB** **X Federal State**	**Performance Measure #17:** Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. **Healthy People 2010 Objective**:				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	60.4	**60.6**	**60.8**	**61**	**61.2**

Narrative: Very low birth weight infants are more likely to survive and thrive if they are born and cared for in an appropriately staffed and equipped medical facility with a high volume of high risk admissions. MCH will continue to monitor this performance measure. There is no national data source for this at the present time. The state does not have influence on private practice referrals or on the percent of low birth weight infants that are delivered at facilities for high-risk deliveries and neonates.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
No FY '01 objective-will continue to monitor		

Type: RF **Category: IB** **X Federal State**	**Performance Measure #18:** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. **Healthy People 2010 Objective**:				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	86	**86.5**	**87**	**87.5**	**88**

Narrative: Quality prenatal care in the first trimester contributes to better health outcomes for mother and infant. Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for the first trimester entry into prenatal. MCH continues to support the Native American prenatal programs.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Continue the Optimal Pregnancy Outcome Program activities.	OPOP to continue providing prenatal education to pregnant women at local health units.	OPOP Programs continued.
Continue support of the Healthy Start Program.	Support Healthy Start through MCH participation on Healthy Start board.	MCH/WIC Nutrition Services Coordinator will participate in at least three-fourths of the

	OPOP and WIC to continue support of Targeted Case Management through referrals of high-risk pregnant women.	scheduled meetings of the Healthy Start in North Dakota, Inc. Board of Directors. OPOP to track referrals made to Targeted Case Management.
Continue to support Native American prenatal programs.	Provide funding for: The Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations. The Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination. The Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services prenatal activities.	Funding provided. Native American rate of first trimester prenatal care will be maintained
Assess data collection activities related to the prenatal behaviors.	Obtain more information on the National PRAMS Survey questions and procedures. Review and revise/refine data collection procedures for New Mothers' Survey by September 30, 2001.	Options for the 2002 New Mothers' Survey will be developed.

Type: RF **Category: IB** **Federal X State**	**Performance Measure # S1:** The percent of children impacted by a CSCC funded community grant whose focus is categorized as "health" by the grantee. **Healthy People 2010 Objective:**				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	30	**31**			
Narrative: *NOTE: This state negotiated measure was discontinued.*					
Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**			**Status/Measurement:**	
Type: P **Category: ES** **Federal X State**	**Performance Measure #S2:** The percent of children with special health care needs who are receiving care coordination services by CSHS. **Healthy People 2010 Objective:**				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	5.5	**5.6**			
Narrative: *NOTE: This state negotiated measure was discontinued.*					
Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**			**Status/Measurement:**	

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S3:** The rate of abuse and neglect in infants and children from birth to age five. **Healthy People 2010 Objective:** 7.4 (Children under 18)				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	6.7	**6.6**	**6.5**	**6.4**	**6.3**

Narrative: Child abuse and neglect can adversely affect the health of families. There are several preventive health activities conducted by state and local preventative health departments that impact parenting/family issues that may contribute to reduced child abuse and neglect. The MCH Director is a member of the State Child Protection Team, which addresses reports of abuse and neglect in state institutions housing children.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Provide technical assistance and consultation to Home Visiting agencies.	Update the Home Visit Provider section of the Newborn Home Visit Directory. Maintain resource inventory for home visiting.	Home Visit Provider section of the Directory updated. Resource inventory continued.
Provide technical assistance to those trained in Infant Massage.	Survey infant massage instructors to determine their network and technical assistance needs. Send infant massage related information to infant massage instructors as appropriate.	Survey distributed and analyzed. Mailings sent.
Continue to provide NCAST information to local health units and other agencies.	Provide technical assistance for those trained in NCAST. Provide NCAST training if needed.	Technical assistance provided to individuals trained in NCAST. NCAST training held, if needed.
Continue distribution of the ***Parenting the First Year*** newsletter to parents of newborns.	Annually update the ***Parenting the First Year*** newsletter mailing list. Continue to distribute the newsletter.	Mailing list updated. ***Parenting the First Year*** newsletter distributed to parents of newborns.
Update the Pediatric Assessment section of the MCH Child Health Services Manual.	The Forms Committee will meet regularly to update the Pediatric Assessment section of the MCH Child Health Services Manual.	Meetings held and Pediatric Assessment section of the Child Health Services Manual finalized.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S4:** Incidence of normal weight among young adults 20-29 years of age. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	47	**48**	**49**	**50**	**51**

Narrative: Data is obtained from weighted data from the Behavioral Risk Factor Survey System. Activities for promotion of healthy weights are coordinated with many agencies. Coordination of activities with various agencies and collations is a major component of the activities under this performance measure.

Annual Performance Objective(s): 10/1/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Conduct a conference/summit on Child Obesity in ND.	In cooperation with the Child Nutrition Programs the Department of Public Instruction, and other partners in the Obesity Prevention Work group finalize funding sources, contract with speakers, locate or develop educational displays, identify pertinent handouts, mail brochures.	Conference will be held.
Coordinated activities of the Obesity Prevention Work Group	Hold monthly meetings between September 2000 and June 2001. Conduct at least one activity in addition to planning and implementing the childhood obesity conference.	Minutes shared with members. Other health professionals will be informed of groups activities.
WIC Education packets related to the prevention of obesity will be developed.	The monthly WIC education packets for 2001 will focus on obesity prevention (increasing activity and promoting healthy eating habits).	Eleven WIC education packets will be produced in 2001.
Participate in activities of ND Healthy Heart Council/5-Plus-5 Communities/ Surveillance and coordinate with MCH activities.	MCH staff will participate in meetings of the ND Healthy Heart Council and the NDHHC 5-Plus-5 Communities and the Surveillance Committees.	Meetings/conference calls attended. Coordinate activities of 5-Plus-5 and 5-A-Day with the Division of Health Promotion.
Review Nutrition Screening Tools for use in MCH and Health Tracks	Review MCH nutrition screening tools and compare with Bright Futures guidelines.	Tools reviewed and revised if needed.

Program.	Revise if needed.	
Coordinate 5-A-Day activities with Division of Health Promotion.	Participate in 5-A-Day meetings/call. Provide opportunities for sharing at meetings of local public health nutritionists.	Meetings and opportunities to share will be documented.
Coordinate activities of local public health nutritionists.	Arrange for two face-to-face and one conference call for local public health nutritionists. Involve local nutritionists in the activities of the Obesity Prevention Workgroup. Coordinate efforts to obtain funding for a statewide Calcium Project.	Meetings/calls will be held. Local nutritionists will have an active part in the Childhood Obesity Summit and other group activities. Efforts to obtain funding will be documented.

Type: P **Category: IB** **Federal X State**	**Performance Measure #S5:** Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services. **Healthy People 2010 Objective:** Objective 21-12

Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	37	**37.5**	**38**	**38.5**	**39**

Narrative: The five-year goal is to incrementally increase the percent of Medicaid eligible children receiving dental services. Projections for FY '01-'05 have been revised to reflect current trends in progress. With the current provider shortage, policy changes to encourage recruitment and retention of providers in rural and underserved areas and their participation in Medicaid will need to be made to continue progress toward the targets.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01 develop/promote policy changes to improve access to dental care.	Convene workgroups from the ND Dental Summit to further define strategies and policies. Work with ND Dental Association, the Primary Care Association and Primary	Work groups convened periodically and progress reported. Policies and programs developed.

	Care Organization to develop policies/programs to increase the number of dental providers in the state.	
Continue data collection on dental provider distribution.	Resurvey dental providers to update the provider distribution database and track trends.	Survey of dental provider distribution completed.
Continue support for the Red River Valley Dental Access Committee.	Attend local coalition meetings. Provide technical assistance as needed.	Participation/support of coalition activities reported.
Conduct formal evaluation of "Project Will Show."	Conduct survey of local referral agencies assessing the usefulness of "Project Will Show" materials. Survey dental providers to determine if "Project Will Show" has improved client attitudes and practices.	Survey of local referral agencies completed. Survey of dental providers completed.

Type: C **Category: DHC** **Federal X State**	**Performance Measure #S6:** Ratio of school nurses to students in ND. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	.18	**.18**	**.18**	**.18**	**.18**

Narrative: At present, we have no reliable data source to report the ratio of nurses to students in ND. The reported ratio of nurses to students in the state beginning with FY '01 is based on a 1999 survey of local health departments and school nurses conducted by the DoH. Without legislative action to provide a source of funding we hope to remain level in the ratio of nurses to students.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Advocate for school health services provided by a school nurse.	Attend statewide meetings of ND School Health Network (NDSHN) semi-annual and Executive NDSHN meetings, advocating for school health services.	Meetings attended.
Provide technical assistance to school nurses, and schools developing school health services programs.	Gather data on services provided by nurses in schools. Conduct follow-up survey to determine ratio of school nurses to students in ND Complete the Policy and Procedure Manual for Nurses providing services in schools. To be distributed to Public Health Units and nurses employed by school districts. Collaborate with Department of Public Instruction (DPI) and Health Promotion (HP) to develop standardization method of reporting services provided in schools.	Data collected. Survey completed. Collaborate with DPI and HP to develop standardization method of reporting services
Monitor School Nurse Legislative Activity.	Provide information on activity of legislature to school nurses in the state.	Information provided to school nurses

Type: P **Category: PBS** **Federal X State**	**Performance Measure #S7:** The number of nonfatal injuries requiring hospitalization for children 19 years of age and under reported in the ND Health Care Claims Database. An increase in the use of E-codes by hospitals. **Healthy People 2010 Objective:**				
Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
	20	**30**			

Narrative:

NOTE: This state negotiated measure was discontinued.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S8:** The proportion of pregnancies that are intended. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	60.6	**61.2**	**61.8**	**62.4**	**63**

Narrative: Unintended pregnancy is serious and costly and occurs frequently. Socially the costs can be measured in unintended births, reduced educational attainment and employment opportunity, greater welfare dependency and increased potential for child abuse and neglect. Economically, health care costs are increased. The consequences of unintended pregnancy are not confined to those occurring in teenagers or unmarried couples. In fact, unintended pregnancy can carry serious consequences at all ages and stages of life. With an unintended pregnancy, the mother is less likely to seek prenatal care in the first trimester. She is less likely to breastfeed and more likely to expose the fetus to harmful substances, such as tobacco and alcohol. The child of such a pregnancy is at greater risk of low birth weight, dying in its first year, being abused and not receiving sufficient resources for healthy development. Pregnancy begun without some degree of planning often prevents individual women and men from participating in preconception risk identification and management.

Annual Performance Objective(s): 10/01/00-9/30/01	Workplan Activities:	Status/Measurement:
Provide family planning services to 14,307 women and men.	Through contracts to 9 delegate agencies with 17 clinic sites assure medical, laboratory, counseling and contraceptive supply services to women and men.	Monitor clinic visit record data and provide feedback to family planning contractors.
Increase adolescents access to information regarding family planning and intendedness of pregnancy.	Provide family planning educational sessions to 100 junior and high schools statewide regarding contraception.	Review progress reports from family planning delegate agencies regarding presentations made.
Increase referrals OPOP and Domestic Violence Programs and the Family Planning Program.	Provide cross training for staffs of both programs about availability of family planning services.	Review of survey of Family Planning referral agencies.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S9:** The percent of women who use tobacco during pregnancy **Healthy People 2010 Objective:**

Projected PM:	CY '01	CY '02	CY '03	CY '04	CY '05
	19.4	19.3	19.2	19.1	19.0

Narrative: Smoking has been linked with many adverse effects on both the developing fetus and mother. Reducing tobacco use during pregnancy has a positive effect on reducing the infant, neonatal, postnatal and perinatal mortality rates, genetic disorders premature birth and on lowering the number of low birth weight deliveries.

Annual Performance Objective(s): 10/01/00-9/30/01	Workplan Activities:	Status/Measurement:
Monitor tobacco use in WIC/OPOP clients.	Data will be collected by WIC/OPOP regarding tobacco use in pregnancy. The OPOP Director will distribute the yearly data report that includes tobacco use information to the OPOP Coordinators.	Statewide OPOP data report sent to each OPOP Coordinator.
Distribute smoking cessation related information to public health.	Collaborate with the State Tobacco program to distribute smoking cessation information to clients in OPOP and WIC.	Smoking cessation information distributed to OPOP and WIC for use with clients.

Partner with the State Tobacco Program to provide a public information campaign.	MCH to provide limited funds to assist the State Tobacco Program in providing a public information campaign in ND.	Funds provided to assist the State Tobacco Program in providing a public information campaign in ND.
Add tobacco exposure/use to MCH forms used by public health	The Forms Committee will review MCH forms and collaborate with the State Tobacco Program to add "tobacco exposure/use" to the MCH forms used by public health.	MCH forms updated to include "tobacco exposure/use."

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S10:** The rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17. **Healthy People 2010 Objective:** 11.1b (2010 Objective: 1-9)

Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
(3-yr. running average)	**72.4**	**72.3**	**72.2**	**72.1**	**72.0**

Narrative: Congenital anomalies and chronic health conditions negatively impact children's quality of life and functional ability. Current research suggests increased rates of asthma across the nation. Between 1996 and 1997, hospitalization of ND children with a principle diagnosis of asthma decreased in number but increased as a percentage of all pediatric hospitalization. According to a CSHS family survey, CSHCN missed school more often than children generally and required increased use of specialized therapy, equipment and supplies. The five-year goal for this state measure is to enhance asthma education, direct services and partnerships in order to decrease hospitalization rates for children with asthma in ND.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
During FY '01, CSHS will promote use of quality standards by providers and families to improve asthma diagnosis and management.	Review available standards for asthma. Explore options to promote family education opportunities for asthma.	Standard of care for asthma will be selected for CSHS promotional use. List of asthma education options will be available.
CSHS will assess ability to pay for specialty care services for children with asthma during FY '01.	Determine financial impact to CSHS if asthma were to be added as an eligible condition. Develop criteria for medical eligibility and covered services.	Fiscal report available and shared with the CSHS Medical Advisory Council. Content added to CSHS policy and procedural manual regarding asthma coverage, if

		financially feasible.
During FY '01, CSHS will collaborate with other stakeholders involved with asthma.	Identify key partners and initiate or facilitate a meeting to identify needs and service gaps for children with asthma.	Meeting will be held and a plan to address needs formulated.

Type: C **Category: ES** **Federal X State**	**Performance Measure #S11:** The percent of CSHCN served by CSHS with a specialty care visit **Healthy People 2010 Objective:** 17.20 (2010 Objective: 16-23)

Projected PM:	**FY '01**	**FY '02**	**FY '03**	**FY '04**	**FY '05**
(3 yr. running average)	**87.6**	**88.1**	**88.6**	**89.1**	**89.6**

Narrative: The number and location of pediatric specialists and related service providers is geographically disproportionate to where CSHCNs live in ND. According to a CSHS family survey, families reported having to travel an average of more than 100 miles one way to visit their child's medical specialist. The five-year goal for this state measure is to enhance availability of specialty care and related services resulting in an increased percent of CSHCN served by CSHS with a specialty care visit.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
Assess ability to pay for travel reimbursement for families served by CSHS in FY '01.	Determine financial impact of adding travel reimbursement as an enabling service. Develop policies and procedures for family travel reimbursement.	Fiscal report will be available. CSHS policy and procedural manual will include content regarding travel reimbursement, if financially feasible.
During FY '01, CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	Disseminate a clinic schedule. Administer and provide on-site clinic management for three different types of multidisciplinary clinics. Write an annual clinic report. Initiate a request for proposal process for multidisciplinary clinic services. Develop and administer CSHS contracts for five different types of multidisciplinary clinics. Write an annual contract report.	Clinics will be held and data for result measures available. Contracts for multidisciplinary clinics and data for result measures will be available
During FY '01, CSHS will collaborate with other stakeholders	Identify potential gaps in multidisciplinary clinic services in ND through contact with	A list of potential clinic services needed to serve CSHCNs in ND will be available as well

in order to enhance the multidisciplinary clinic infrastructure in the state.	clinic coordinators and the CSHS Medical Advisory Council. Conduct a review of clinic services provided by Title V CSHCN programs in other states.	as recommendations to enhance the State's infrastructure.
During FY '01, CSHS will assess potential application of telemedicine services for the CSHCN population in ND.	A literature review on use of telemedicine for the CSHCN population will be completed. On-site visits to telemedicine sites will be conducted.	A report will be available that includes recommended applications for telemedicine use to enhance availability of specialty care and related services for CSHCNs and their families.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S12:** The percent of women who use a multivitamin supplement prior to pregnancy. **Healthy People 2010 Objective:**

Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY '05**
	42	**44**	**46**	**48**	**49**

Narrative: The above objectives are based on the 1999 New Mothers' Survey (NMS), which found that 38% of the women consumed a vitamin supplement every day prior to their pregnancy. In the future, we will track this objective by use of the Behavior Risk Factor Survey.

Annual Performance Objective(s): 10/01/00-9/30/01	**Workplan Activities:**	**Status/Measurement:**
MCH staff will participate in the ND March of Dimes Folic Acid Task Force activities.	In January 2001, MCH and the WIC Program will participate in Folic Acid Awareness Month.	Activities will be reported.
Vitamin consumption behavior information from both the New Mothers' Survey and the Behavioral Risk Factor Survey System will be	Disseminate NMS final report. Provide information to the Folic Acid Task Force.	Activities will be reported.

disseminated.	Involve local nutritionists in activities to promote folic acid.	
Monitor WIC activities related to education on the importance of folic acid.	WIC annual monitoring activities (for 2000-2001) will include a component to evaluate the extent to which post-partum women (especially first time mothers) receive information on folic acid.	Findings will be shared with WIC staff.

Type: RF **Category: PBS** **Federal X State**	**Performance Measure #S13:** The rate of deaths to children aged 0-19 caused by unintentional injuries per 100,000 children. **Healthy People 2010 Objective:**				
Projected PM:	**CY '01**	**CY '02**	**CY '03**	**CY '04**	**CY 05**
	24.5	**24.5**	**24**	**23.5**	**23.5**

Narrative: Unintentional injuries are the leading cause of death for ND children after their first year of life. Federal performance measures exist to track motor vehicle deaths to children aged 1-14. This state measure will allow tracking for non-motor vehicle deaths, as well as motor vehicle deaths to adolescents 15-19.

Annual Performance Objective(s): 10/01/98-9/30/99	**Workplan Activities:**	**Status/Measurement:**
Help ensure the safety of children in the childcare setting.	Collaborate with childcare agencies to promote safety of children in childcare setting. MCH will be a key player in planning the "Visioning Retreat" with Head Start and the Childcare Division in the DHS. MCH staff will participate in the fall "Visioning Retreat." MCH staff will work with Head Start to sponsor joint training February 13 & 14, 2001.	Monitor number of trainings and consultations conducted by R&R nurses at childcare settings. MCH Division Director will participate in an October 2000 Visioning Retreat for Childcare along with Head Start, Childcare Division and other stakeholders. MCH staff will help plan, participate and attend the training for childcare staff.

Maintain blood lead surveillance reported to MCH.	MCH staff will monitor blood lead levels reported to MCH. Elevated levels will be tracked and managed with the help of public health services.	Activities will be reported.
Continue serving as ND representative for US Consumer Product Safety Commission.	Conduct recall effectiveness checks and special projects as assigned. Distribute media releases and a quarterly newsletter, "Building Blocks to Safety."	Assignments completed as requested. Newsletter published quarterly.
Assist local health departments, law enforcement agencies, Safe Community Programs and others in developing community-based injury prevention projects.	Provide technical assistance, training, data and materials to local entities on injury-specific topics. Sponsor a statewide Injury Prevention Conference in November 2000. Collaborate with Safe Kids, EMSC, Native American Injury Prevention Coalition in developing injury prevention projects. Continue coordinating Shaken Baby Syndrome Prevention campaign.	Number of local agencies receiving technical assistance, materials, etc. Conference held. Number of projects coordinated with other agencies/organizations. Focus of campaign, number of materials distributed.
Review fatality information for children 0-19.	Participate in North Dakota Child Fatality Review Panel. Review all death certificates to children under age 18 and conduct in-depth review on specific cases.	Number of Child Fatality Review Panel meetings attended. Number of cases reviewed.

4.2 Other Program Activities

See above tables.

Activities within each pyramid level were discussed in either the above tables or within the narrative under the needs assessment section. If related activities were not provided, they were alluded to under each area of the pyramid as discussed in the needs assessment.

4.3 Public Input [Section 505(a)(5)(F)]

The SSDI Coordinator established a data committee composed of staff from both MCH and CSHS Divisions. This committee assisted the SSDI Coordinator in completing the five-year needs assessment with input from other Title V staff. This data was presented at a November 1999 Title V retreat of multi-disciplinary, multi-agency attendees. This data was used to rank priority needs for each of the five populations (maternal, infants, children, children with special health care needs and adolescents). Once the ranking of needs was completed, the second day of the retreat was spent discussing various solutions to meet identified needs. The results of this two-day retreat were used as part of the planning to establish state performance measures and activities.

A member of the MCH Advisory Committee was a participant at the November retreat. The advisory committee was subsequently informed of the identified priorities and offered the opportunity to offer input.

Federal and state negotiated performance measures were placed on the web sites of both the MCH and CSHS Divisions with requests for input. Stakeholders were asked to identify additional priority needs and suggest actions to address those priority needs. This was the first time this approach was used and 15 responses were received. Some of the comments offered included expansion of the state's CHIP program, additional school health services, the need for parent education and training, the use of state tobacco settlement funds for smoking cessation and prevention programs, and increased behavioral and mental health services. As this is continued over time, hopefully more consumers will access the web sites.

Information on the availability of the Year 2001 Grant was again made public through major newspapers across the state. Few requests for copies of the grant were received.

Local agencies for the first time were supplied copies of the performance measures, both federal and state, when they received their annual requests for proposals (RFPs) from the MCH Division. Thus local agencies will be aware of and can address similar measures identified as needs within their local communities.

In the annual CSHS contract proposal application process, providers were asked to rank the impact of the proposed program or project on federal and state performance measures. Administrative staff ranked the proposals that were submitted based on several criteria, one of which was their degree of impact on performance measures specifically for children with special health care needs.

4.4 Technical Assistance [Section 509 (a)(4)]

Form #15.

V. SUPPORTING DOCUMENTS
5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10% of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance and information systems) and other infrastructure needed to maintain service delivery and policy-making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations.** States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. **State Support for Communities.** State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. **Coordination of Health Components of Community-Based Systems.** A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. **Coordination of Health Services with Other Services at the Community Level.** A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000.00 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled “Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions” in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-

(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000.00 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, US Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may

result in the imposition of a monetary penalty of up to $1,000.00 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

WORKSHEET FOR DETERMINING PRIORITY OF HEALTH AREAS

MATERNAL, INFANTS, CHILDREN, CSHCN, ADOLESCENTS

#	Health Area	Size A	Seriousness B	Intervention Effectiveness C	"PEARL" Score D	A+2(B)+C+D Total Score E	Final Rank F
MATERNAL							
1	Healthy Weight	9					
2	Domestic Violence / Abuse	5					
3	Unplanned Pregnancy	9					
4	Pre-conception Counseling	9					
5	Initiation of Prenatal Care	7					
6	Pre-Pregnancy Vitamin Intake	9					
INFANTS							
7	Infant Mortality Rates	1					
8	Birth Weight	5					
9	SIDS Related Behaviors	5					
10	Smoking Effects	7					
11	Breast feeding	9					
CHILDREN							
12	Overweight / Physical Activity	5					
13	Child Deaths	3					
14	Access	9					
15	Causes of Pediatric Hospitalization	5					
16	Immunization	7					
17	Abuse / Neglect	5					
CSHCN							
18	Chronic Health Conditions	7					
19	Programs Serving CSHCN	5					
20	Congenital Anomalies	5					
21	Specialty Care Providers	9					
22	Insurance Coverage Status	7					
23	Degree of Coordinated Care	9					
ADOLESCENTS							
24	Tobacco Use	7					
25	Suicide Deaths	1					
26	Motor Vehicle Deaths	1					
27	Teen Birth Rate	3					
28	Sexually Transmitted Diseases	9					
29	Eating Disorders	9					
30	Alcohol Use	9					

5.4 Core Health Status Indicator Forms

5.5 Core Health Status Indicator Detail Sheets

5.6 Developmental Health Status Indicator Forms

5.7 Developmental Health Status Indicator Detail Sheets

5.8 All Other Forms (Forms 2-15)

5.9 National “Core” Performance Measure Detail Sheets

5.10 State "Negotiated" Performance Measure Detail Sheets

5.11 Outcome Measure Detail Sheets

5.12 Notes for ERP Forms 1 through 16